Professional SOLUTIONS INSURANCE COMPANY

14001 University Avenue, Clive, Iowa 50325-8258
515-313-4701 • Fax 515-313-4886
Toll-Free 800-864-8026 • Toll-Free Fax 800-510-6370

March 11, 2011

FILED
MAR 14 2011
STATE OF ILLINOIS
DEPARTMENT OF INSURANCE
SPRINGFIELD, ILLINOIS

RECEIVED
MAR 14 2011
STATE OF ILLINOIS
DEPARTMENT OF INSURANCE
SPRINGFIELD

Illinois Insurance Division
Attn: Gayle Neuman
320 West Washington Street
Springfield, IL 62767

VIA OVERNIGHT MAIL

RE: Professional Solutions Insurance Company
FEIN: 42-1520773
NAIC Number: 11127
Physicians and Surgeons Professional Liability Rate Filing
Filing Number: PSIC MD 2011
Proposed Effective Date: 03/14/2011 New Business and 09/01/2011 Renewals

Dear Ms. Neuman:

Professional Solutions Insurance Company (PSIC) currently has on file with the Illinois Insurance Division a claims made professional liability rating manual for our physicians and surgeons professional liability program. PSIC would like to submit for your review and approval an amended claims made professional liability rating manual to replace the manual that is currently pending review with the Illinois Insurance Division under filing number: PSIC MD 2010 Rewrite. Please see the attached explanatory memorandum and side-by-side rating manual comparison which detail all the changes being made.

Please be advised that that Professional Solutions Insurance Company continues to utilize National Independent Statistical Service for our reporting of statistics.

If you have any questions or need any additional information regarding this filing, please feel free to contact me directly. I thank you in advance for your attention to this matter.

Sincerely,

Juli Frank

Juliana Frank
Assistant Director of Compliance
PH: (515) 313-4557
FX: (515) 313-4476
Email: jfrank@ncmic.com

Encl.

1-0
MEM
RAT

Neuman, Gayle

From: Juli Frank [JFrank@ncmic.com]
Sent: Tuesday, June 28, 2011 3:41 PM
To: Neuman, Gayle
Subject: RE: Professional Solutions Ins Co - Filing #PSIC MD 2011

Ms. Neuman,

Yes, the referenced filing was put into effect on March 14, 2011.

Thanks,

Juliana Frank
Assistant Director of Compliance
NCMIC Group, Inc.
Tel: (800) 321-7015 Ext. 4557
Fax: (515) 313-4476
Email: jfrank@ncmic.com

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, June 28, 2011 3:30 PM
To: Juli Frank
Subject: Professional Solutions Ins Co - Filing #PSIC MD 2011

Ms. Frank,

The Department of Insurance completed its review of the filing referenced above on June 27, 2011. Originally, Professional Solutions requested the filing be effective March 14, 2011. Was the filing put into effect on March 14, 2011 or do you wish to have a different effective date?

Your prompt response is appreciated.

Gayle Neuman
Illinois Department of Insurance
Property & Casualty Compliance
(217) 524-6497

Please refer to the Property & Casualty Review Checklists before submitting any filing. The checklists can be accessed through the Department's website at www.insurance.illinois.gov.

Section 754

RECEIVED

MAR 14 2011

STATE OF ILLINOIS
DEPARTMENT OF INSURANCE
SPRINGFIELD

Section 754.EXHIBIT A Summary Sheet (Form RF-3)

FORM (RF-3)

SUMMARY SHEET

Change in Company's premium or rate level produced by rate revision effective 03/14/2011.

	(1) Coverage	(2) Annual Premium Volume (Illinois) *	(3) Percent Change (+or-) **
1.	Automobile Liability Private Passenger		
	Commercial		
2	Automobile Physical Damag Private Passenger		
	Commercial		
3.	Liability Other Than Auto		
4.	Burglary and Theft		
5.	Glass		
6.	Fidelity		
7.	Surety		
8.	Boiler and Machinery		
9.	Fire		
10.	Extended Coverage		
11.	Inland Marine		
12.	Homeowners		
13.	Commercial Multi-Peril		
14.	Crop Hail		
15.	Other Medical Malpractice Life of Insurance	$4,730,579	-2.6%

Does filing only apply to certain territory (territories) or certain Classes? If so, specify: This filing applies to all territories and classes.

Brief description of filing. (If filing follows rates of an advisory Organization, specify organization): Independent Physicians and Surgeons rate/rule filing

~~Claims-made step factors and extended reporting period factors~~

*Adjusted to reflect all prior rate changes.

**Change in Company's premium level which will result from application of new rates.

Professional Solutions Insurance Company
Name of Company

Juliana Frank, Asst. Director of Compliance
Official – Title

filing # PSIC MD 2011

ILLINOIS CERTIFICATION FOR MEDICAL MALPRACTICE RATES

(215 ILCS 5/155.18)(3) states that medical liability rates shall be certified in such filing by an officer of the company and a qualified actuary that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience.

I, Roger L. Schlueter, a duly authorized officer of Professional Solutions Insurance Company, am authorized to certify on behalf of the Company making this filing that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience, and that I am knowledgeable of the laws, regulations and bulletins applicable to the policy rates that are the subject of this filing.

I, Charles W. Mitchell, FCAS, MAAA, a duly authorized actuary of Milliman am authorized to certify on behalf of Professional Solutions Insurance Company making this filing that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience, and that I am knowledgeable of the laws, regulations and bulletins applicable to the policy rates that are the subject of this filing.

Chief Financial Officer — 3/11/11

Signature and Title of Authorized Insurance Company Officer — Date

Charles W. Mitchell — 3/11/11

Signature, Title and Designation of Authorized Actuary — Date

Insurance Company FEIN 42-1520773 Filing Number PSIC MD 2011

Insurer's Address 14001 University Avenue

City Clive State Iowa Zip Code 50325-8258

Contact Person's:
-Name and E-mail Juliana Frank, Asst Director of Compliance jfrank@ncmic.com

-Direct Telephone and Fax Number Phone: 515-313-4557 Fax: 515-313-4476

Neuman, Gayle

From: Juli Frank [JFrank@ncmic.com]
Sent: Monday, April 04, 2011 10:43 AM
To: Neuman, Gayle
Subject: PSIC MD 2011
Attachments: IL PSIC Rating Manual 03-2011.pdf

Dear Ms. Neuman,

Professional Solutions Insurance Company submitted rate filing, PSIC MD 2011, on March 11, 2011. The Tail Factor for years 5+ is incorrect on page 4 of the rating manual. Please see the attached rating manual in which the Tail Factor has been updated from 2.022 to 1.87.

<<IL PSIC Rating Manual 03-2011.pdf>>

Should you have any questions regarding this matter, please do not hesitate to contact me.

Sincerely,

Juliana Frank

Assistant Director of Compliance

NCMIC Group, Inc.

Tel: (800) 321-7015 Ext. 4557

Fax: (515) 313-4476

Email: jfrank@ncmic.com

Premium for this extension is derived by rating the policy based upon the claims made step factor determined by using the previous carrier's retroactive date.

B. Automatic Reporting Extension

This provision applies when coverage under the policy ends, either by action of the insured or the Company through cancellation, termination or non-renewal.

Under the circumstances stated above, the Company will provide a thirty (30) day Automatic Reporting Extension which allows claims to be reported during this time that result from incidents that happened during the time the coverage was in force. The thirty (30) day Automatic Reporting Extension does not apply if the insured purchases any subsequent insurance that replaces in whole or in part the coverage provided by this policy.

Within thirty (30) days of when the policy coverage terminates, the Company must advise the insured of the availability of Extended Reporting Coverage, the premium cost, and the importance of buying this additional coverage extension, commonly called "Tail Coverage".

The insured will have the greater of sixty (60) days from the date the coverage is terminated, or thirty (30) days from the date of notice, to accept the Extended Reporting Coverage in writing.

C. Extended Reporting Coverage, also called Tail Coverage

Extended Reporting Coverage will be provided for an unlimited time period with aggregate liability limits equal to or less than those of the expired coverage to report claims which arose from incidents that occurred when the coverage was in force. The liability limits provided by this option are the only limits that shall be applicable to the unlimited time period designated above. Extended Reporting Coverage can be applied to individual or entity policies.

The following factors will be applied to the expiring annual premium:

# of Years Completed in Claims Made Program	Tail Factor
1	3.680
2	2.860
3	2.179
4	2.022
5	2.022

Professional Solutions Insurance Company cannot cancel the Extended Reporting Coverage except for non-payment of the additional premium. Premium is due in full at the time of purchase; no payment plans will be offered.

The Company provides Extended Reporting Coverage automatically, at no additional charge, in the event that the insured dies or becomes permanently disabled.

The Company also provides Extended Reporting Coverage automatically, at no additional charge, in the event the insured retires at or after age fifty-five (55) and after having been continuously insured with Professional Solutions Insurance Company under a claims made policy for five (5) years. The Extended Reporting Coverage premium will be discounted for Insureds who retire at or after age fifty-five (55) with fewer than five (5) years of continuous coverage as follows:

# of Years of Continuous Coverage	Extended Reporting Coverage Credit
1 full year	20%
2 full years	40%
3 full years	60%
4 full years	80%

Professional Solutions Insurance Company

Illinois Physicians and Surgeons Professional Liability Program

Explanatory Memorandum

The following items within the rating manual have been revised in our currently approved Physicians and Surgeons Professional Liability rating manual as a result of this filing. Please see the side-by-side comparison of the old and new rating manuals for detailed information regarding the revisions outlined below.

- We adjusted the tail factors and revised the wording regarding the tail coverage calculation to clarify that the factors are based on the expiring annual premium.
- We revised the Experience Modification eligibility to apply to groups of 5 or more practitioners with at least $250,000 total manual premium instead of 10 or more practitioners with at least $100,000 total manual premium. Our Underwriter feels that adjusting the eligibility requirement for Experience Rating to $250,000 will serve to improve the credibility of our experience rating methodology. (Please note that we do not currently have any groups priced using the Experience Modification under $250,000 in manual premium.)
- We revised the charge for Additional Interests that are financially and medically controlled by the Named Insured from 5% to 0%.
- We have revised the following medical specialties under Section XVI. Classification Plan. (Please note that we currently do not have any insureds under any of these 3 specialties.)

  89154-Orthopedic excl. Spine, Major Surgery from Class 10/Rel 3.35 to Class 9/Rel 3.00
  80154-Orthopedic incl. Spine, Major Surgery from Class 12/Rel 4.50 to Class 10/Rel 3.35
  80156-Plastic (NOC), Major Surgery from Class 12/Rel 4.50 to Class 9/Rel 3.00

- We revised the claims-made step factors as follows:

Year	Claims-Made Step Factor
1	0.250
2	0.500
3	0.780
4	0.925
Mature	1.000

Side by Side Comparison

Attached please find a comparison for Professional Solutions Insurance Company's currently pending Physicians and Surgeons Professional Liability Manual and Professional Solutions Insurance Company's newly revised Physicians and Surgeons Professional Liability Manual. All information that has been deleted from the currently pending manual is in brackets and all new information that has been added to the new proposed manual is underlined.

PROFESSIONAL SOLUTIONS INSURANCE COMPANY

STATE OF ILLINOIS

PHYSICIANS AND SURGEONS

MEDICAL PROFESSIONAL LIABILITY MANUAL

CLAIMS MADE COVERAGE

PROFESSIONAL SOLUTIONS INSURANCE COMPANY

STATE OF ILLINOIS

PHYSICIANS AND SURGEONS

MEDICAL PROFESSIONAL LIABILITY MANUAL

CLAIMS MADE COVERAGE

I. APPLICATION OF THIS MANUAL-ELIGIBILITY

This claims made program covers Physicians and Surgeons engaged in the rendering of professional services specific to their disciplines. Refer to the classification plan for a description of each risk/rating category for physicians and surgeons.

Employees of health care professionals are also included as insureds for their acts while performing duties within the scope of their discipline while under the direction and supervision of the insured named in the coverage summary. Refer to the listing of the mid-level healthcare providers who may be covered by either a shared or separate limit of liability.

This program also provides coverage for both medical clinics and individual practicing physicians for the liability exposure of a partnership, corporation or professional association on either a separate or shared limit basis. Refer to the professional entity coverage section for a description of the partnership, corporation or professional association rating factors.

II. PREMIUM DETERMINATION

1. Determine the manual rate for the appropriate territory.
2. Refer to Classification Listing and apply the factor for the appropriate class specialty being rated.
3. Apply the appropriate increase limit factor.
4. Apply the appropriate claims made step factor to reach the undiscounted premium.
5. .Apply discounts, as appropriate, for part-time or new practitioner.
6. Apply any applicable credits/debits for experience rating.
7. Apply any applicable credits/debits for schedule rating.
8. Apply the deductible credit, if applicable.
9. Apply rounding.
10. Example Premium Calculation:

    Assume the full time undiscounted premium is $1,000 and no new practitioner or part-time status applies. Additional credits or debits will be applied in consecutive order.

    $1,000 x .95 = $950.00 (Claims Free credit of 5%)
    $950.00 x .95 = $902.50 (Schedule Rating credit of 5%)
    $902.50 = $903.00 (Apply rounding)

III. POLICY PERIOD

The policy period shall be for a one-year term. Insureds added or removed mid-term will be pro-rated.

IV. WHOLE DOLLAR PREMIUM RULE

All premiums shown on the policy and endorsements shall be rounded to the nearest whole dollar. If the premium is .50 or greater, round to next higher whole dollar. If the premium is .49 or less, round down. In the event of cancellation, the return premium shall be rounded to the nearest whole dollar. Rounding is the last step of the premium calculation.

Example: $1,234.30 is rounded to $1,234.
$1,234.60 is rounded to $1,235.

V. PRACTICE LOCATION

The following parameters will be applied for healthcare providers who practice in multiple territories or states:

A. For healthcare providers classified as No Surgery or Minor Surgery, the location of the primary office practice will determine the manual rate.
B. For healthcare providers classified as Anesthesiology, Intensive Care/Critical Care Medicine, Pathology, Radiology or Major Surgery, the location of the primary healthcare facility practice will determine the manual rate.

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This program also provides coverage for both medical clinics and individual practicing physicians for the liability exposure of a partnership, corporation or professional association on either a separate or shared limit basis. Refer to the professional entity coverage section for a description of the partnership, corporation or professional association rating factors.

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1. Determine the manual rate for the appropriate territory.
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6. Apply any applicable credits/debits for experience rating.
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8. Apply the deductible credit, if applicable.
9. Apply rounding.
10. Example Premium Calculation:

    Assume the full time undiscounted premium is $1,000 and no new practitioner or part-time status applies. Additional credits or debits will be applied in consecutive order.

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A. For healthcare providers classified as No Surgery or Minor Surgery, the location of the primary office practice will determine the manual rate.
B. For healthcare providers classified as Anesthesiology, Intensive Care/Critical Care Medicine, Pathology, Radiology or Major Surgery, the location of the primary healthcare facility practice will determine the manual rate.

C. If a healthcare provider practices equally in two or more states or territories, the rate from the highest territory or state will be applied.

For the purposes of this section, primary means 51% or more of the healthcare provider's practice time is spent in the given territory or state.

The insured must be licensed in all states where practicing.

VI. POLICY CANCELLATION

A. Cancellation By the Insured

The insured may cancel the policy by mailing or delivering notice to the Company stating when such cancellation shall be effective.

This policy will remain in full force and effect until its regular anniversary date unless the policy is cancelled sooner by the Company in accordance with the laws of the State of Illinois.

If the insured cancels the policy, earned premium shall be computed in accordance with the standard short rate tables and procedure. If the Company cancels the policy, earned premium shall be computed pro rata.

B. Cancellation/Non-Renewal By the Company

The Company may cancel or non-renew the policy in accordance with the insurance laws of the State of Illinois. Standard cancellation notice will be sent sixty (60) days prior to cancellation, except that in the event of non-payment of premium, then not less than ten (10) days prior notice will be given.

VII. PREMIUM PAYMENT OPTIONS

1.	Annual	
2.	Semi-Annual	50% prepayment required
3.	Quarterly	25% prepayment required as the initial down payment with remaining payments of 25% each due at 3, 6 & 9 months after policy inception

There is no installment fee charge or interest charged for utilizing the premium payment options. Additional premiums for policy changes occurring during the current policy term shall be computed pro rata of the annual premium. If there are no remaining installments, additional premium resulting from changes in coverage may be due immediately as a separate transaction. If the policy is issued with a final fully discounted premium less than $500, the policy must be billed on an annual basis.

VIII. RENEWALS

The policy will be renewed upon receipt of the required premium on or before the date of each successive policy period. The renewal premium shall be based on rates in effect on the renewal or anniversary date. The applicable forms and endorsements must be made a part of the policy. Additional premiums for policy changes occurring during the current policy term shall be computed pro rata of the annual premium.

IX. SPECIAL PROVISIONS

A. Retroactive Coverage

This extension covers incidents which occurred subsequent to the prior carrier's retroactive date, but which are neither known nor reported as of the inception date of the replacement coverage written by Professional Solutions Insurance Company. The insured may apply for a Retroactive Date that is equal to the retroactive date shown on the previous policy.

C. If a healthcare provider practices equally in two or more states or territories, the rate from the highest territory or state will be applied.

For the purposes of this section, primary means 51% or more of the healthcare provider's practice time is spent in the given territory or state.

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The Company may cancel or non-renew the policy in accordance with the insurance laws of the State of Illinois. Standard cancellation notice will be sent sixty (60) days prior to cancellation, except that in the event of non-payment of premium, then not less than ten (10) days prior notice will be given.

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This extension covers incidents which occurred subsequent to the prior carrier's retroactive date, but which are neither known nor reported as of the inception date of the replacement coverage written by Professional Solutions Insurance Company. The insured may apply for a Retroactive Date that is equal to the retroactive date shown on the previous policy.

Premium for this extension is derived by rating the policy based upon the claims made step factor determined by using the previous carrier's retroactive date.

B. Automatic Reporting Extension

This provision applies when coverage under the policy ends, either by action of the insured or the Company through cancellation, termination or non-renewal.

Under the circumstances stated above, the Company will provide a thirty (30) day Automatic Reporting Extension which allows claims to be reported during this time that result from incidents that happened during the time the coverage was in force. The thirty (30) day Automatic Reporting Extension does not apply if the insured purchases any subsequent insurance that replaces in whole or in part the coverage provided by this policy.

Within thirty (30) days of when the policy coverage terminates, the Company must advise the insured of the availability of Extended Reporting Coverage, the premium cost, and the importance of buying this additional coverage extension, commonly called "Tail Coverage".

The insured will have the greater of sixty (60) days from the date the coverage is terminated, or thirty (30) days from the date of notice, to accept the Extended Reporting Coverage in writing.

C. Extended Reporting Coverage, also called Tail Coverage

Extended Reporting Coverage will be provided for an unlimited time period with aggregate liability limits equal to or less than those of the expired coverage to report claims which arose from incidents that occurred when the coverage was in force. The liability limits provided by this option are the only limits that shall be applicable to the unlimited time period designated above. Extended Reporting Coverage can be applied to individual or entity policies.

The following factors will be applied to the ~~undiscounted mature claims made premium in effect at the time the policy is terminated to calculate the extended reporting endorsement~~ premium:

# of Years Completed in Claims Made Program	Tail Factor
1	~~0.92~~
2	~~1.43~~
3	~~1.70~~
~~4+~~	~~1.87~~

Professional Solutions Insurance Company cannot cancel the Extended Reporting Coverage except for non-payment of the additional premium. Premium is due in full at the time of purchase; no payment plans will be offered.

The Company provides Extended Reporting Coverage automatically, at no additional charge, in the event that the insured dies or becomes permanently disabled.

The Company also provides Extended Reporting Coverage automatically, at no additional charge, in the event the insured retires at or after age fifty-five (55) and after having been continuously insured with Professional Solutions Insurance Company under a claims made policy for five (5) years. The Extended Reporting Coverage premium will be discounted for Insureds who retire at or after age fifty-five (55) with fewer than five (5) years of continuous coverage as follows:

# of Years of Continuous Coverage	Extended Reporting Coverage Credit
1 full year	20%
2 full years	40%
3 full years	60%
4 full years	80%

Premium for this extension is derived by rating the policy based upon the claims made step factor determined by using the previous carrier's retroactive date.

B. Automatic Reporting Extension

This provision applies when coverage under the policy ends, either by action of the insured or the Company through cancellation, termination or non-renewal.

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The following factors will be applied to the expiring annual premium:

# of Years Completed in Claims Made Program	Tail Factor
1	3.680
2	2.860
3	2.179
4	2.022
5	2.022

Professional Solutions Insurance Company cannot cancel the Extended Reporting Coverage except for non-payment of the additional premium. Premium is due in full at the time of purchase; no payment plans will be offered.

The Company provides Extended Reporting Coverage automatically, at no additional charge, in the event that the insured dies or becomes permanently disabled.

The Company also provides Extended Reporting Coverage automatically, at no additional charge, in the event the insured retires at or after age fifty-five (55) and after having been continuously insured with Professional Solutions Insurance Company under a claims made policy for five (5) years. The Extended Reporting Coverage premium will be discounted for Insureds who retire at or after age fifty-five (55) with fewer than five (5) years of continuous coverage as follows:

# of Years of Continuous Coverage	Extended Reporting Coverage Credit
1 full year	20%
2 full years	40%
3 full years	60%
4 full years	80%

D. Change in Rating Classification

In the event of a change in exposure or medical specialty of the practitioner, a premium charge reflecting the difference between the previous and such new exposure or specialty shall be calculated and collected at the time of such change unless:

1. otherwise eligible for Extended Reporting Coverage at no additional charge;
2. with regard to medical specialty, both the prior and the current specialty fall within the same class;
3. the exposure or medical specialty of the practitioner changed more than 4 years prior while insured under claims made coverage; or
4. the exposure or medical specialty of the practitioner changed while insured under occurrence coverage.

E. Locum Tenens

Locum Tenens working in the place of an insured shall be provided coverage at no additional premium, for a period not to exceed sixty (60) days per policy term. A completed application must be submitted to the Company for prior underwriting approval.

X. DISCOUNTS

A. New Practitioner

A new practitioner is defined as a person who has completed his or her training, whose only contact with patients has been in the course of his or her training, and who has not been previously insured by Professional Solutions Insurance Company.

1st year	50% credit
2nd year	30% credit
3rd year	10% credit

Those who receive a new practitioner credit will not be eligible to receive any further credits, except for schedule rating and the experience rating modification. The total of all new practitioner and schedule rating credits will not exceed 50%.

B. Part-Time Practitioner

A practitioner must practice 20 hours or less per week to become eligible for this credit. Surgery classes are not eligible for the part-time credit. The insured must complete an application for part-time credit. If the application is approved, credits will be given by year according to the following schedule:

1st year	30% credit
2nd year	40% credit
3rd year	50% credit

Those who receive a part-time practitioner credit will not be eligible to receive any further credits, except for schedule rating and the experience rating modification. The total of all part-time practitioner and schedule rating credits will not exceed 50%.

XI. EXPERIENCE RATING

Claims free credits

A claim is defined as a claim closed with incurred indemnity equal to or greater than $10,000.00 or allocated loss adjustment expense (ALAE) payments plus any Company established reserves for loss or ALAE exceeding $100,000.

A claim free credit shall apply if the insured has achieved at least 3 years without a claim.

D. Change in Rating Classification

In the event of a change in exposure or medical specialty of the practitioner, a premium charge reflecting the difference between the previous and such new exposure or specialty shall be calculated and collected at the time of such change unless:

1. otherwise eligible for Extended Reporting Coverage at no additional charge;
2. with regard to medical specialty, both the prior and the current specialty fall within the same class;
3. the exposure or medical specialty of the practitioner changed more than 4 years prior while insured under claims made coverage; or
4. the exposure or medical specialty of the practitioner changed while insured under occurrence coverage.

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1st year	50% credit
2nd year	30% credit
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1st year	30% credit
2nd year	40% credit
3rd year	50% credit

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XI. EXPERIENCE RATING

Claims free credits

A claim is defined as a claim closed with incurred indemnity equal to or greater than $10,000.00 or allocated loss adjustment expense (ALAE) payments plus any Company established reserves for loss or ALAE exceeding $100,000.

A claim free credit shall apply if the insured has achieved at least 3 years without a claim.

The following schedule will apply:

3 yrs	5%
4 yrs	10%
5+ yrs	15%

Claims debits

Claim frequency debit factors:

Three (3) claims opened in the past five (5) years:	5%
Four (4) claims opened in the past five (5) years:	7%
Five (5) claims opened in the past five (5) years:	10%

The debit will not be based on an action that was filed or settled more than five (5) years immediately preceding the issuance or renewal of the policy.

Documentation, including copies of judgments, awards or stipulations of settlement will be requested and reviewed where available.

To obtain and verify experience applicable to each prospective insured, the Company will seek claim information from:

a. The applicant
b. The agent or broker
c. All previous insurers with respect to the experience period in question.

XII. SCHEDULE RATING

Professional Solutions Insurance Company will use the following schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of Professional Solutions Insurance Company uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

The premium for a risk may be modified in accordance with the following, subject to a maximum modification of a 25% credit to a 25% debit to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule rating plan are subject to periodic review. The actual determination of the appropriate credit or debit will be determined through the underwriting review of the applicant's application.

SCHEDULE RATING PROGRAM		Maximum Credit	Maximum Debit
Historical Loss Experience	The frequency or severity of claims for the insured(s) is greater/less than expected experience for an insured(s) of the same classification/size or recognition of unusual circumstances of claims in the loss experience.	25%	25%
Cumulative Years of Patient Experience	The insured(s) demonstrates a stable, longstanding practice and/or significant degree of experience in their current area of medicine.	10%	10%
Classification Anomalies	Characteristics of a particular insured that differentiate the insured from other members of the same class, or recognition of a recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.	25%	25%
Claims Anomalies	Economic, societal or jurisdictional changes or trends that will influence the frequency or severity of claims, or unusual circumstances of a claim(s) which understate/overstate the severity of the claims(s).	10%	10%
Management Control Procedures	Specific operational activities undertaken by the insured to reduce the frequency and/or severity of claims.	10%	10%

The following schedule will apply:

3 yrs	5%
4 yrs	10%
5+ yrs	15%

Claims debits

Claim frequency debit factors:

Three (3) claims opened in the past five (5) years:	5%
Four (4) claims opened in the past five (5) years:	7%
Five (5) claims opened in the past five (5) years:	10%

The debit will not be based on an action that was filed or settled more than five (5) years immediately preceding the issuance or renewal of the policy.

Documentation, including copies of judgments, awards or stipulations of settlement will be requested and reviewed where available.

To obtain and verify experience applicable to each prospective insured, the Company will seek claim information from:

a. The applicant
b. The agent or broker
c. All previous insurers with respect to the experience period in question.

XII. SCHEDULE RATING

Professional Solutions Insurance Company will use the following schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of Professional Solutions Insurance Company uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

The premium for a risk may be modified in accordance with the following, subject to a maximum modification of a 25% credit to a 25% debit to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule rating plan are subject to periodic review. The actual determination of the appropriate credit or debit will be determined through the underwriting review of the applicant's application.

SCHEDULE RATING PROGRAM		Maximum Credit	Maximum Debit
Historical Loss Experience	The frequency or severity of claims for the insured(s) is greater/less than expected experience for an insured(s) of the same classification/size or recognition of unusual circumstances of claims in the loss experience.	25%	25%
Cumulative Years of Patient Experience	The insured(s) demonstrates a stable, longstanding practice and/or significant degree of experience in their current area of medicine.	10%	10%
Classification Anomalies	Characteristics of a particular insured that differentiate the insured from other members of the same class, or recognition of a recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.	25%	25%
Claims Anomalies	Economic, societal or jurisdictional changes or trends that will influence the frequency or severity of claims, or unusual circumstances of a claim(s) which understate/overstate the severity of the claims(s).	10%	10%

Number/Type of Patient Exposures	Size and/or demographics of the patient population which influences the frequency and/or severity of claims.	10%	10%
Organizational Size / Structure	The organization's size and processes are such that economies of scale are achieved while servicing the insured.	10%	10%
Medical Standards, Quality & Claim Review	Presence of (1) committees that meet on a routine basis to review medical procedures, treatments, and protocols and then assist in the integration of such into the practice, (2) Committees meet to assure the quality of the health care services being rendered and/or (3) Committees to provide consistent review of claims/incidents that have occurred and developed corrective action.	10%	10%
Other Risk Management Practices and Procedures	Additional activities undertaken with specific intention of reducing the frequency or severity of claims.	10%	10%
Training, Accreditation & Credentialing	The insured(s) exhibits greater/less than normal participation and support of such activities.	10%	10%
Record – Keeping Practices	Degree to which insured incorporates methods to maintain quality patient records, referrals, and test results	10%	10%
Utilization of Monitoring Equipment, Diagnostic Tests or Procedures	Demonstrating the willingness to expend the time and capital to incorporate the latest advances in medical treatment and equipment into the practice, or failure to meet accepted standards of care.	10%	10%

XIII. EXPERIENCE RATING MODIFICATION

A. Eligibility

This experience rating plan may apply to a group policy of ~~ten~~ or more practitioners with total manual premium of at least ~~$100,000.~~

B. Application

The experience modification developed according to this rule will apply to the otherwise applicable premium generated for the group, reflecting the applicable limits of liability and any other rating factors, discounts, or surcharges that may apply. The experience modification factor will be applied prior to the application of any deductible credit. The experience modification factor will apply to premium at time of policy issuance or renewal, as well as to the premium associated with any subsequent policy modification during the policy term.

C. Experience Used

To the extent that it is available, a five-year experience period for each individual member and the corporation/partnership will be used to calculate the group's experience modification under this plan. In no instance will less than three years' experience be utilized. The prior years' experience will be compiled by report year. The experience period will start with the second prior policy period, and end with the sixth prior policy period. The experience period ending immediately before the policy period to which the modification will apply is excluded from the experience period.

Experience of the group related to policy periods during which the entity was not covered by Professional Solutions Insurance Company will be included in the experience modification calculations to the extent such prior experience is considered to be complete and accurate.

D. Experience Period Premium Subject to Experience Rating

The development of the Experience Period Premium Subject to Experience Rating (Subject Premium) is as follows:

Management Control Procedures	Specific operational activities undertaken by the insured to reduce the frequency and/or severity of claims.	10%	10%
Number/Type of Patient Exposures	Size and/or demographics of the patient population which influences the frequency and/or severity of claims.	10%	10%
Organizational Size / Structure	The organization's size and processes are such that economies of scale are achieved while servicing the insured.	10%	10%
Medical Standards, Quality & Claim Review	Presence of (1) committees that meet on a routine basis to review medical procedures, treatments, and protocols and then assist in the integration of such into the practice, (2) Committees meet to assure the quality of the health care services being rendered and/or (3) Committees to provide consistent review of claims/incidents that have occurred and developed corrective action.	10%	10%
Other Risk Management Practices and Procedures	Additional activities undertaken with specific intention of reducing the frequency or severity of claims.	10%	10%
Training, Accreditation & Credentialing	The insured(s) exhibits greater/less than normal participation and support of such activities.	10%	10%
Record – Keeping Practices	Degree to which insured incorporates methods to maintain quality patient records, referrals, and test results	10%	10%
Utilization of Monitoring Equipment, Diagnostic Tests or Procedures	Demonstrating the willingness to expend the time and capital to incorporate the latest advances in medical treatment and equipment into the practice, or failure to meet accepted standards of care.	10%	10%

XIII. EXPERIENCE RATING MODIFICATION

A. Eligibility

This experience rating plan may apply to a group policy of five or more practitioners with total manual premium of at least $250,000.

B. Application

The experience modification developed according to this rule will apply to the otherwise applicable premium generated for the group, reflecting the applicable limits of liability and any other rating factors, discounts, or surcharges that may apply. The experience modification factor will be applied prior to the application of any deductible credit. The experience modification factor will apply to premium at time of policy issuance or renewal, as well as to the premium associated with any subsequent policy modification during the policy term.

C. Experience Used

To the extent that it is available, a five-year experience period for each individual member and the corporation/partnership will be used to calculate the group's experience modification under this plan. In no instance will less than three years' experience be utilized. The prior years' experience will be compiled by report year. The experience period will start with the second prior policy period, and end with the sixth prior policy period. The experience period ending immediately before the policy period to which the modification will apply is excluded from the experience period.

Experience of the group related to policy periods during which the entity was not covered by Professional Solutions Insurance Company will be included in the experience modification calculations to the extent such prior experience is considered to be complete and accurate.

D. Experience Period Premium Subject to Experience Rating

The development of the Experience Period Premium Subject to Experience Rating (Subject Premium) is as follows:

First, for each year in the experience period, the premium at present rate level is calculated. This calculation involves rating the group's historical exposures in each experience period using the current rates and rating plan factors. The experience period premium at present rates should reflect the $200,000 policy limit underlying this experience rating plan, as well as any discounts, surcharges or other rating factors that are currently applicable, with the exception of any deductible credit. The claims-made step factor used in developing the premiums for each experience period should be consistent with the claim history provided. For example, if a physician's retroactive date implies a second year claims-made policy exposure, but a longer-term history of claims is available, then the retroactive date should be adjusted to reflect the more mature claims experience.

The next step in the development of Subject Premium is to adjust the premiums at present rates to reflect claim cost inflation. The calculation involves de-trending the experience period premiums at present rates from the current claim cost level to the experience period claim cost level.

E. Experience Period Losses Subject to Experience Rating

The development of the Experience Period Losses Subject to Experience Rating (Subject Losses) is as follows:

All claims, open, closed, loss only, loss expense only, paid or reserved, are included for purposes of determining the Experience Modification Factor. Actual claims from each year in the experience period are compiled. Claims are compiled by report year/policy period. In each case, incurred to date loss values (i.e., paid indemnity plus outstanding reserves) are capped at $200,000 per claim and allocated loss adjustment expenses are included in full. The sum of the limited indemnity and unlimited ALAE is then limited to the maximum single loss of $300,000 (limited loss and ALAE).

The next step in the development of the Subject Losses is to include a factor to reflect losses which are "Incurred But Not Reported", or IBNR. IBNR factors are applied to the expected losses (Subject Premium x Expected Loss and ALAE Ratio) for each policy year in the experience period.

The Subject Losses are the sum of the actual limited losses and ALAE and IBNR.

F. Valuation Date

All of the losses for the experience period should be valued as of 6 months prior to the issuance/renewal date. This date will be referred to as the "valuation date".

G. Actual Experience Loss Ratio

The Actual Experience Loss Ratio (AELR) is determined by dividing the Experience Period Subject Losses by the Experience Period Subject Premium.

H. Expected Loss Ratio

The Expected Loss Ratio (ELR) for the group is equal to the state-specific individual physician expected loss ratio adjusted to reflect group underwriting expense savings.

I. Credibility

The credibility will be calculated by taking the square root of the following fraction:

$$\frac{\text{Experience Period Base Class Equivalent Exposures}}{2{,}700}$$

The base class equivalent exposures are calculated as the total Experience Rating Subject Premium divided by the current mature claims-made base rate at $200,000 policy limits. The maximum credibility a risk may receive is 100%. If a risk receives less than 100% credibility, the remaining credibility (100% - actual credibility) is given to unity (i.e., no debit and no credit).

First, for each year in the experience period, the premium at present rate level is calculated. This calculation involves rating the group's historical exposures in each experience period using the current rates and rating plan factors. The experience period premium at present rates should reflect the $200,000 policy limit underlying this experience rating plan, as well as any discounts, surcharges or other rating factors that are currently applicable, with the exception of any deductible credit. The claims-made step factor used in developing the premiums for each experience period should be consistent with the claim history provided. For example, if a physician's retroactive date implies a second year claims-made policy exposure, but a longer-term history of claims is available, then the retroactive date should be adjusted to reflect the more mature claims experience.

The next step in the development of Subject Premium is to adjust the premiums at present rates to reflect claim cost inflation. The calculation involves de-trending the experience period premiums at present rates from the current claim cost level to the experience period claim cost level.

E. Experience Period Losses Subject to Experience Rating

The development of the Experience Period Losses Subject to Experience Rating (Subject Losses) is as follows:

All claims, open, closed, loss only, loss expense only, paid or reserved, are included for purposes of determining the Experience Modification Factor. Actual claims from each year in the experience period are compiled. Claims are compiled by report year/policy period. In each case, incurred to date loss values (i.e., paid indemnity plus outstanding reserves) are capped at $200,000 per claim and allocated loss adjustment expenses are included in full. The sum of the limited indemnity and unlimited ALAE is then limited to the maximum single loss of $300,000 (limited loss and ALAE).

The next step in the development of the Subject Losses is to include a factor to reflect losses which are "Incurred But Not Reported", or IBNR. IBNR factors are applied to the expected losses (Subject Premium x Expected Loss and ALAE Ratio) for each policy year in the experience period.

The Subject Losses are the sum of the actual limited losses and ALAE and IBNR.

F. Valuation Date

All of the losses for the experience period should be valued as of 6 months prior to the issuance/renewal date. This date will be referred to as the "valuation date".

G. Actual Experience Loss Ratio

The Actual Experience Loss Ratio (AELR) is determined by dividing the Experience Period Subject Losses by the Experience Period Subject Premium.

H. Expected Loss Ratio

The Expected Loss Ratio (ELR) for the group is equal to the state-specific individual physician expected loss ratio adjusted to reflect group underwriting expense savings.

I. Credibility

The credibility will be calculated by taking the square root of the following fraction:

$$\frac{\text{Experience Period Base Class Equivalent Exposures}}{2{,}700}$$

The base class equivalent exposures are calculated as the total Experience Rating Subject Premium divided by the current mature claims-made base rate at $200,000 policy limits. The maximum credibility a risk may receive is 100%. If a risk receives less than 100% credibility, the remaining credibility (100% - actual credibility) is given to unity (i.e., no debit and no credit).

J. Experience Modification Factor

The experience modification factor for the working layer of premium (first $200,000/$600,000 policy limits premium) is calculated as follows:

Experience Modification Factor = [AELR/ELR – 1] x Credibility + 1

The experience modification factor for the excess layer of premium will equal the square root of the working layer factor.

A final Combined Experience Modification Factor is then determined by applying the experience modifications by layer. The Combined Experience Modification Factor is applicable to the premium gross of deductible.

XIV. DEDUCTIBLE

The insured may elect to pay a deductible towards the amount paid to claimants as damages. The deductible will be collected after the payment of the claim. The following credits apply to the discounted premium.

	Per-Claim with Per-Insured Aggregate Deductible (Loss Only)				
Policy Limits	**$5K/$15K**	**$10K/$30K**	**$15K/$45K**	**$20K/$60K**	**$25K/$75K**
$100,000 / $300,000	0.962	0.938	0.913	0.889	0.867
$200,000 / $600,000	0.972	0.953	0.935	0.916	0.900
$250,000 / $750,000	0.974	0.957	0.940	0.923	0.907
$500,000 / $1,000,000	0.979	0.965	0.951	0.938	0.925
$1,000,000 / $3,000,000	0.983	0.972	0.961	0.950	0.940
$2,000,000 / $4,000,000	0.986	0.977	0.968	0.959	0.951

	Per-Claim with Per-Insured Aggregate Deductible (Loss Only)				
Policy Limits	**$50K/$150K**	**$100K/$300K**	**$200K/$600K**	**$250K/$750K**	**$500K/$1.5M**
$100,000 / $300,000	0.802	0.680	N/A	N/A	N/A
$200,000 / $600,000	0.851	0.759	0.632	N/A	N/A
$250,000 / $750,000	0.863	0.778	0.661	0.599	N/A
$500,000 / $1,000,000	0.889	0.820	0.725	0.675	0.588
$1,000,000 / $3,000,000	0.911	0.856	0.780	0.740	0.670
$2,000,000 / $4,000,000	0.927	0.882	0.820	0.788	0.731

	Per-Claim No Aggregate Deductible (Loss Only)				
Policy Limits	**$5K**	**$10K**	**$15K**	**$20K**	**$25K**
$100,000 / $300,000	0.954	0.926	0.896	0.867	0.847
$200,000 / $600,000	0.966	0.944	0.922	0.899	0.885
$250,000 / $750,000	0.969	0.948	0.928	0.908	0.893
$500,000 / $1,000,000	0.975	0.958	0.941	0.926	0.914
$1,000,000 / $3,000,000	0.980	0.966	0.953	0.940	0.931
$2,000,000 / $4,000,000	0.983	0.972	0.962	0.951	0.944

	Per-Claim No Aggregate Deductible (Loss Only)				
Policy Limits	**$50K**	**$100K**	**$200K**	**$250K**	**$500K**
$100,000 / $300,000	0.782	0.680	N/A	N/A	N/A
$200,000 / $600,000	0.836	0.740	0.632	N/A	N/A
$250,000 / $750,000	0.849	0.760	0.641	0.599	N/A
$500,000 / $1,000,000	0.878	0.806	0.709	0.662	0.588
$1,000,000 / $3,000,000	0.902	0.844	0.767	0.730	0.663
$2,000,000 / $4,000,000	0.920	0.873	0.809	0.780	0.726

J. Experience Modification Factor

The experience modification factor for the working layer of premium (first $200,000/$600,000 policy limits premium) is calculated as follows:

Experience Modification Factor = [AELR/ELR – 1] x Credibility + 1

The experience modification factor for the excess layer of premium will equal the square root of the working layer factor.

A final Combined Experience Modification Factor is then determined by applying the experience modifications by layer. The Combined Experience Modification Factor is applicable to the premium gross of deductible.

XIV. DEDUCTIBLE

The insured may elect to pay a deductible towards the amount paid to claimants as damages. The deductible will be collected after the payment of the claim. The following credits apply to the discounted premium.

	Per-Claim with Per-Insured Aggregate Deductible (Loss Only)				
Policy Limits	**$5K/$15K**	**$10K/$30K**	**$15K/$45K**	**$20K/$60K**	**$25K/$75K**
$100,000 / $300,000	0.962	0.938	0.913	0.889	0.867
$200,000 / $600,000	0.972	0.953	0.935	0.916	0.900
$250,000 / $750,000	0.974	0.957	0.940	0.923	0.907
$500,000 / $1,000,000	0.979	0.965	0.951	0.938	0.925
$1,000,000 / $3,000,000	0.983	0.972	0.961	0.950	0.940
$2,000,000 / $4,000,000	0.986	0.977	0.968	0.959	0.951

	Per-Claim with Per-Insured Aggregate Deductible (Loss Only)				
Policy Limits	**$50K/$150K**	**$100K/$300K**	**$200K/$600K**	**$250K/$750K**	**$500K/$1.5M**
$100,000 / $300,000	0.802	0.680	N/A	N/A	N/A
$200,000 / $600,000	0.851	0.759	0.632	N/A	N/A
$250,000 / $750,000	0.863	0.778	0.661	0.599	N/A
$500,000 / $1,000,000	0.889	0.820	0.725	0.675	0.588
$1,000,000 / $3,000,000	0.911	0.856	0.780	0.740	0.670
$2,000,000 / $4,000,000	0.927	0.882	0.820	0.788	0.731

	Per-Claim No Aggregate Deductible (Loss Only)				
Policy Limits	**$5K**	**$10K**	**$15K**	**$20K**	**$25K**
$100,000 / $300,000	0.954	0.926	0.896	0.867	0.847
$200,000 / $600,000	0.966	0.944	0.922	0.899	0.885
$250,000 / $750,000	0.969	0.948	0.928	0.908	0.893
$500,000 / $1,000,000	0.975	0.958	0.941	0.926	0.914
$1,000,000 / $3,000,000	0.980	0.966	0.953	0.940	0.931
$2,000,000 / $4,000,000	0.983	0.972	0.962	0.951	0.944

	Per-Claim No Aggregate Deductible (Loss Only)				
Policy Limits	**$50K**	**$100K**	**$200K**	**$250K**	**$500K**
$100,000 / $300,000	0.782	0.680	N/A	N/A	N/A
$200,000 / $600,000	0.836	0.740	0.632	N/A	N/A
$250,000 / $750,000	0.849	0.760	0.641	0.599	N/A
$500,000 / $1,000,000	0.878	0.806	0.709	0.662	0.588
$1,000,000 / $3,000,000	0.902	0.844	0.767	0.730	0.663
$2,000,000 / $4,000,000	0.920	0.873	0.809	0.780	0.726

Policy Limits	Per-Insured Aggregate Deductible (Loss Only) $5K	$10K	$15K	$20K	$25K
$100,000 / $300,000	0.982	0.967	0.948	0.927	0.916
$200,000 / $600,000	0.986	0.975	0.961	0.944	0.937
$250,000 / $750,000	0.988	0.977	0.964	0.949	0.941
$500,000 / $1,000,000	0.990	0.981	0.971	0.959	0.953
$1,000,000 / $3,000,000	0.992	0.985	0.977	0.967	0.962
$2,000,000 / $4,000,000	0.993	0.987	0.981	0.973	0.969

Policy Limits	Per-Insured Aggregate Deductible (Loss Only) $50K	$100K	$200K	$250K	$500K
$100,000 / $300,000	0.869	0.792	0.680	0.605	N/A
$200,000 / $600,000	0.902	0.831	0.742	0.700	0.600
$250,000 / $750,000	0.909	0.844	0.749	0.699	0.615
$500,000 / $1,000,000	0.927	0.874	0.796	0.747	0.691
$1,000,000 / $3,000,000	0.941	0.899	0.837	0.798	0.747
$2,000,000 / $4,000,000	0.952	0.917	0.866	0.835	0.795

Additional deductible options are available based upon specific group size and specialty. Refer to underwriting

XV. ENDORSED COVERAGES – Coverage Options

Accelerated Vesting For Extended Reporting Period Endorsement - Form PSIC-CM-02

This endorsement amends the years of continuous coverage requirement for the Extended Reporting Endorsement at no additional charge upon retirement.

Active Military Suspension Endorsement - Form PSIC-CM-03

This endorsement suspends coverage, including premium payments, if an insured is called to active military duty. This endorsement provides coverage for claims arising from acts, errors or omissions that occurred prior to the inception of the active military leave. There is no coverage for acts, errors or omissions during the period of active military duty. For claims made policies, because the policy does not cancel, there is no need for the purchase of Extended Reporting Coverage (Tail) while on active military duty.

Additional Interests Endorsement - Form PSIC-CM-05

This optional endorsement provides coverage for an additional interest. For an individual practice, the charge for this endorsement will be up to 15% of the named insured's undiscounted manual premium for each additional interest. For a group practice, the charge for this endorsement will be up to 15% of the undiscounted manual rate of the top 5 highest rated healthcare providers for each additional interest.

The addition of an additional interest will be based upon the underwriter's assessment of additional exposure imputed to an insured physician and/or surgeon, solo practitioner corporation, partnership or multi shareholder corporation.

Locations or services being provided by the **additional interest** to or on behalf of the Named Insured are financially and medically controlled by the Named Insured.	~~5%~~
Locations or services being provided by the **additional interest** to or on behalf of the Named Insured are not financially controlled by the Named Insured.	10%
Locations or services being provided by the **additional interest** to or on behalf of the Named Insured are not financially and medically controlled by the Named Insured.	15%

Temporary Leave of Absence Endorsement - Form PSIC-CM-06

This endorsement may be utilized if an insured must take a leave of absence from their practice. Insureds who become disabled or take a leave of absence shall become eligible for suspension of coverage at a rate reduction of 90% of the otherwise applicable rate for the period of disability or leave of absence. The period

Policy Limits	Per-Insured Aggregate Deductible (Loss Only) $5K	$10K	$15K	$20K	$25K
$100,000 / $300,000	0.982	0.967	0.948	0.927	0.916
$200,000 / $600,000	0.986	0.975	0.961	0.944	0.937
$250,000 / $750,000	0.988	0.977	0.964	0.949	0.941
$500,000 / $1,000,000	0.990	0.981	0.971	0.959	0.953
$1,000,000 / $3,000,000	0.992	0.985	0.977	0.967	0.962
$2,000,000 / $4,000,000	0.993	0.987	0.981	0.973	0.969

Policy Limits	Per-Insured Aggregate Deductible (Loss Only) $50K	$100K	$200K	$250K	$500K
$100,000 / $300,000	0.869	0.792	0.680	0.605	N/A
$200,000 / $600,000	0.902	0.831	0.742	0.700	0.600
$250,000 / $750,000	0.909	0.844	0.749	0.699	0.615
$500,000 / $1,000,000	0.927	0.874	0.796	0.747	0.691
$1,000,000 / $3,000,000	0.941	0.899	0.837	0.798	0.747
$2,000,000 / $4,000,000	0.952	0.917	0.866	0.835	0.795

Additional deductible options are available based upon specific group size and specialty. Refer to underwriting

XV. ENDORSED COVERAGES – Coverage Options

Accelerated Vesting For Extended Reporting Period Endorsement - Form PSIC-CM-02

This endorsement amends the years of continuous coverage requirement for the Extended Reporting Endorsement at no additional charge upon retirement.

Active Military Suspension Endorsement - Form PSIC-CM-03

This endorsement suspends coverage, including premium payments, if an insured is called to active military duty. This endorsement provides coverage for claims arising from acts, errors or omissions that occurred prior to the inception of the active military leave. There is no coverage for acts, errors or omissions during the period of active military duty. For claims made policies, because the policy does not cancel, there is no need for the purchase of Extended Reporting Coverage (Tail) while on active military duty.

Additional Interests Endorsement - Form PSIC-CM-05

This optional endorsement provides coverage for an additional interest. For an individual practice, the charge for this endorsement will be up to 15% of the named insured's undiscounted manual premium for each additional interest. For a group practice, the charge for this endorsement will be up to 15% of the undiscounted manual rate of the top 5 highest rated healthcare providers for each additional interest.

The addition of an additional interest will be based upon the underwriter's assessment of additional exposure imputed to an insured physician and/or surgeon, solo practitioner corporation, partnership or multi shareholder corporation.

Locations or services being provided by the **additional interest** to or on behalf of the Named Insured are financially and medically controlled by the Named Insured.	0%
Locations or services being provided by the **additional interest** to or on behalf of the Named Insured are not financially controlled by the Named Insured.	10%
Locations or services being provided by the **additional interest** to or on behalf of the Named Insured are not financially and medically controlled by the Named Insured.	15%

Temporary Leave of Absence Endorsement - Form PSIC-CM-06

This endorsement may be utilized if an insured must take a leave of absence from their practice. Insureds who become disabled or take a leave of absence shall become eligible for suspension of coverage at a rate reduction of 90% of the otherwise applicable rate for the period of disability or leave of absence. The period

must extend for a minimum length of sixty (60) days or more up to a maximum of one hundred eighty (180) days or until renewal. The lower premium will apply retroactively to the first day of the disability or leave.

This option provides continued protection to the provider who experiences a temporary interruption in his or her practice (subject to the stated eligibility requirements), for claims arising from acts, errors or omissions which occurred prior to the inception of the disability or leave. There is no coverage for acts, errors or omissions during the leave or disability period. Because the policy does not cancel, there is no need for the purchase of Extended Reporting Coverage (Tail).

If disabled, proof of disability must be submitted to the Company for approval, and the calculation of the credit will be on a pro rata basis for the period of the qualifying disability.

While on disability or leave, credit toward extended reporting vesting will continue to accrue, and the insured must continue to pay premiums when due.

Eligible Situations For Temporary Leave of Absence: Short-Term Disability, Maternity Leave, Military Leave or any other reason pre-approved by Professional Solutions Insurance Company – Does not apply to vacations.

Extended Reporting Endorsement - Form PSIC-CM-07

This endorsement provides coverage for an unlimited time period with aggregate liability limits equal to or less than those of the expired coverage to report claims, which arose from incidents that occurred when the coverage was in force. The liability limits provided by this option are the only limits that shall be applicable to the unlimited time period designated above. This endorsement can be applied to group or entity policies.

Covered Full Time Equivalent Healthcare Provider Endorsement - Form PSIC-CM-08

A Full-time Equivalency (FTE) is used to accommodate multiple healthcare providers sharing one or more full-time positions within the given specialty. This endorsement provides one separate limit of liability to be shared by the covered FTE healthcare providers within the same FTE position as designated in the endorsement. All covered FTE healthcare providers within an FTE position must have the same specialty. The premium for the FTE position is based on the total hours of practice of the FTE position and the full-time, mature rate for the given specialty.

Covered Healthcare Provider Slot Endorsement - Form PSIC-CM-09

A slot is used to accommodate one full-time position for a given specialty in practices with a high position turnover. This endorsement provides one separate limit of liability to be shared by the covered slot healthcare providers within the same slot position as designated in the endorsement. All covered slot healthcare providers within a slot position must have the same specialty. The premium for the slot position is based on the full-time, mature rate for the given specialty.

Covered Physician Locum Tenens Endorsement - Form PSIC-CM-10

This endorsement adds coverage for the substitute physician or surgeon listed on the endorsement while the named insured is temporarily absent from professional practice. There is no additional premium for this endorsement.

Illinois Restricted Practice Endorsement - Form PSIC-CM-IL-03

This endorsement excludes the designated specialty, procedure or practice activity for the insured(s) specified on the endorsement.

Vicarious Liability for Affiliated Healthcare Provider Endorsement - Form PSIC-CM-12

Coverage is provided for the vicarious liability of the affiliated healthcare provider(s) stated in the endorsement, who at the time of the alleged incident, were not otherwise named as an insured under the policy. There is a 25% additional premium charge for each affiliated physician and a 3% additional premium charge for each affiliated mid-level healthcare provider.

must extend for a minimum length of sixty (60) days or more up to a maximum of one hundred eighty (180) days or until renewal. The lower premium will apply retroactively to the first day of the disability or leave.

This option provides continued protection to the provider who experiences a temporary interruption in his or her practice (subject to the stated eligibility requirements), for claims arising from acts, errors or omissions which occurred prior to the inception of the disability or leave. There is no coverage for acts, errors or omissions during the leave or disability period. Because the policy does not cancel, there is no need for the purchase of Extended Reporting Coverage (Tail).

If disabled, proof of disability must be submitted to the Company for approval, and the calculation of the credit will be on a pro rata basis for the period of the qualifying disability.

While on disability or leave, credit toward extended reporting vesting will continue to accrue, and the insured must continue to pay premiums when due.

Eligible Situations For Temporary Leave of Absence: Short-Term Disability, Maternity Leave, Military Leave or any other reason pre-approved by Professional Solutions Insurance Company – Does not apply to vacations.

Extended Reporting Endorsement - Form PSIC-CM-07

This endorsement provides coverage for an unlimited time period with aggregate liability limits equal to or less than those of the expired coverage to report claims, which arose from incidents that occurred when the coverage was in force. The liability limits provided by this option are the only limits that shall be applicable to the unlimited time period designated above. This endorsement can be applied to group or entity policies.

Covered Full Time Equivalent Healthcare Provider Endorsement - Form PSIC-CM-08

A Full-time Equivalency (FTE) is used to accommodate multiple healthcare providers sharing one or more full-time positions within the given specialty. This endorsement provides one separate limit of liability to be shared by the covered FTE healthcare providers within the same FTE position as designated in the endorsement. All covered FTE healthcare providers within an FTE position must have the same specialty. The premium for the FTE position is based on the total hours of practice of the FTE position and the full-time, mature rate for the given specialty.

Covered Healthcare Provider Slot Endorsement - Form PSIC-CM-09

A slot is used to accommodate one full-time position for a given specialty in practices with a high position turnover. This endorsement provides one separate limit of liability to be shared by the covered slot healthcare providers within the same slot position as designated in the endorsement. All covered slot healthcare providers within a slot position must have the same specialty. The premium for the slot position is based on the full-time, mature rate for the given specialty.

Covered Physician Locum Tenens Endorsement - Form PSIC-CM-10

This endorsement adds coverage for the substitute physician or surgeon listed on the endorsement while the named insured is temporarily absent from professional practice. There is no additional premium for this endorsement.

Illinois Restricted Practice Endorsement - Form PSIC-CM-IL-03

This endorsement excludes the designated specialty, procedure or practice activity for the insured(s) specified on the endorsement.

Vicarious Liability for Affiliated Healthcare Provider Endorsement - Form PSIC-CM-12

Coverage is provided for the vicarious liability of the affiliated healthcare provider(s) stated in the endorsement, who at the time of the alleged incident, were not otherwise named as an insured under the policy. There is a 25% additional premium charge for each affiliated physician and a 3% additional premium charge for each affiliated mid-level healthcare provider.

Illinois Vicarious Liability Risks Excluded Endorsement - Form PSIC-CM-IL-04

This endorsement excludes any vicarious liability arising from professional services provided by, or which should have been provided by, any excluded healthcare provider(s) designated on the endorsement.

XVI. CLASSIFICATION PLAN – Refer to rate sheet for manual rate information.

ISO Specialty Codes M.D.	ISO Specialty Codes D.O.	Class	Description	FACTOR
80999		1	Administrative excl. Direct Patient Care	0.650
80133		1	Aerospace Medicine	0.650
80254		1	Allergy/Immunology	0.650
80256		1	Dermatology - No Surgery	0.650
80240		1	Forensic & Legal Medicine	0.650
80248		1	Nutrition	0.650
80233		1	Occupational Medicine	0.650
80263		1	Ophthalmology - No Surgery	0.650
80235		1	Physical & Rehab Med. excl. Chronic Pain Management	0.650
80231		1	Preventive Medicine - No Surgery	0.650
80251		1	Psychosomatic Medicine - No Surgery	0.650
80236		1	Public Health - No Surgery	0.650
80237		2	Diabetes - No Surgery	0.850
80238		2	Endocrinology - No Surgery	0.850
80243		2	Geriatrics - No Surgery	0.850
80244		2	Gynecology - No Surgery	0.850
80260		2	Nephrology - No Surgery	0.850
80262		2	Nuclear Medicine	0.850
80268		2	Physician (NOC) - No Surgery	0.850
80993		2	Podiatry - Soft Tissue	0.850
80249		2	Psychiatry - No Surgery	0.850
80252		2	Rheumatology - No Surgery	0.850
80182		3	Anesthesiology incl. Chronic Pain Management	1.000
80183		3	Anesthesiology	1.000
80255		3	Cardiovascular Disease - No Surgery	1.000
80420		3	Family Practice, GP (excl. OB) - No Surgery	1.000
80241		3	Gastroenterology - No Surgery	1.000
80245		3	Hematology - No Surgery	1.000
80246		3	Infectious Diseases - No Surgery	1.000
80257		3	Internal Medicine - No Surgery	1.000
80302		3	Oncology - No Surgery	1.000
80268		3	Orthopedic Diagnostic (office only) - No Surgery	1.000
80265		3	Otorhinolaryngology - No Surgery	1.000
80182		3	Pain Management	1.000
80266		3	Pathology - No Surgery	1.000
80267		3	Pediatrics - No Surgery	1.000
80269		3	Pulmonary Diseases - No Surgery	1.000
80425		3	Radiation Oncology	1.000
80287		4	Nephrology - Minor Surgery	1.250
80301		4	Oncology - Minor Surgery	1.250
80289		4	Ophthalmology - Minor Surgery	1.250
80114		4	Ophthalmology - Major Surgery	1.250
80294		4	Pulmonary Diseases - Minor Surgery	1.250

Illinois Vicarious Liability Risks Excluded Endorsement - Form PSIC-CM-IL-04

This endorsement excludes any vicarious liability arising from professional services provided by, or which should have been provided by, any excluded healthcare provider(s) designated on the endorsement.

XVI. CLASSIFICATION PLAN – Refer to rate sheet for manual rate information.

ISO Specialty Codes M.D.	ISO Specialty Codes D.O.	Class	Description	FACTOR
80999		1	Administrative excl. Direct Patient Care	0.650
80133		1	Aerospace Medicine	0.650
80254		1	Allergy/Immunology	0.650
80256		1	Dermatology - No Surgery	0.650
80240		1	Forensic & Legal Medicine	0.650
80248		1	Nutrition	0.650
80233		1	Occupational Medicine	0.650
80263		1	Ophthalmology - No Surgery	0.650
80235		1	Physical & Rehab Med. excl. Chronic Pain Management	0.650
80231		1	Preventive Medicine - No Surgery	0.650
80251		1	Psychosomatic Medicine - No Surgery	0.650
80236		1	Public Health - No Surgery	0.650
80237		2	Diabetes - No Surgery	0.850
80238		2	Endocrinology - No Surgery	0.850
80243		2	Geriatrics - No Surgery	0.850
80244		2	Gynecology - No Surgery	0.850
80260		2	Nephrology - No Surgery	0.850
80262		2	Nuclear Medicine	0.850
80268		2	Physician (NOC) - No Surgery	0.850
80993		2	Podiatry - Soft Tissue	0.850
80249		2	Psychiatry - No Surgery	0.850
80252		2	Rheumatology - No Surgery	0.850
80182		3	Anesthesiology incl. Chronic Pain Management	1.000
80183		3	Anesthesiology	1.000
80255		3	Cardiovascular Disease - No Surgery	1.000
80420		3	Family Practice, GP (excl. OB) - No Surgery	1.000
80241		3	Gastroenterology - No Surgery	1.000
80245		3	Hematology - No Surgery	1.000
80246		3	Infectious Diseases - No Surgery	1.000
80257		3	Internal Medicine - No Surgery	1.000
80302		3	Oncology - No Surgery	1.000
80268		3	Orthopedic Diagnostic (office only) - No Surgery	1.000
80265		3	Otorhinolaryngology - No Surgery	1.000
80182		3	Pain Management	1.000
80266		3	Pathology - No Surgery	1.000
80267		3	Pediatrics - No Surgery	1.000
80269		3	Pulmonary Diseases - No Surgery	1.000
80425		3	Radiation Oncology	1.000
80287		4	Nephrology - Minor Surgery	1.250
80301		4	Oncology - Minor Surgery	1.250
80289		4	Ophthalmology - Minor Surgery	1.250
80114		4	Ophthalmology - Major Surgery	1.250
80294		4	Pulmonary Diseases - Minor Surgery	1.250

80120	4	Urology - Minor Surgery	1.250
80281	5	Cardiovascular Disease - Minor Surgery	1.500
80282	5	Dermatology - Minor Surgery	1.500
80271	5	Diabetes - Minor Surgery	1.500
80272	5	Endocrinology - Minor Surgery	1.500
80421	5	Family Practice, GP (excl. OB) - Minor Surgery	1.500
80274	5	Gastroenterology - Minor Surgery	1.500
80276	5	Geriatrics - Minor Surgery	1.500
80277	5	Gynecology - Minor Surgery	1.500
80278	5	Hematology - Minor Surgery	1.500
80222	5	Hospitalist	1.500
80279	5	Infectious Diseases - Minor Surgery	1.500
80284	5	Internal Medicine - Minor Surgery	1.500
80261	5	Neurology - No Surgery	1.500
80291	5	Otorhinolaryngology - Minor Surgery	1.500
80293	5	Pediatrics - Minor Surgery	1.500
80208	5	Physical & Rehab Med. incl. Pain Mgmt - Minor Procedures	1.500
80294	5	Physician (NOC) - Minor Surgery	1.500
80253	5	Radiology Diagnostic - No Surgery	1.500
80268	5	Urgent Care excl. Emergency Med. - No Surgery	1.500
80145	5	Urology - Major Surgery	1.500
80283	6	Intensive & Critical Care Medicine	1.650
80288	6	Neurology - Minor Surgery	1.650
80292	6	Pathology - Minor Surgery	1.650
80208	6	Physical & Rehab Med. incl. Pain Mgmt - Major Procedures	1.650
80280	6	Radiology Diagnostic - Minor Surgery	1.650
80360	6	Radiology Interventional - including invasive procedures	1.650
80101	7	Broncho-Esophagology - Major Surgery	2.150
80103	7	Endocrinology - Major Surgery	2.150
80104	7	Gastroenterology - Major Surgery	2.150
80105	7	Geriatrics - Major Surgery	2.150
80804	7	Neonatal/Perinatal Medicine	2.150
80108	7	Nephrology - Major Surgery	2.150
80159	7	Otorhinolaryngology excl. Facial Plastic – Major Surgery	2.150
80115	8	Colon & Rectal - Major Surgery	2.500
80164	8	Oncology - Major Surgery	2.500
80117	8	Physician (NOC) - Major Invasive Procedures	2.500
80160	8	Rhinology Surgery	2.500
80102	9	Emergency Medicine - excl. Major Surgery	3.000
80420	9	Family Practice, GP - incl. OB & assist CS	3.000
80143	9	General (NOC) excl. Bariatrics - Major Surgery	3.000
80169	10	Hand - Major Surgery	3.350
80154	~~10~~	Orthopedic excl. Spine - Major Surgery	~~3.350~~
80155	10	Otorhinolaryngology incl. Facial Plastic - Major Surgery	3.350
80166	11	Abdominal - Major Surgery	3.750
80157	11	Emergency Medicine - incl. Major Surgery	3.750
80167	11	Gynecology - Major Surgery	3.750
80170	11	Head & Neck - Major Surgery	3.750
80141	12	Cardiac - Major Surgery	4.500
80150	12	Cardiovascular Disease - Major Surgery	4.500
80156	12	Dermatology - Major Surgery	4.500
80154	~~12~~	Orthopedic incl. Spine - Major Surgery	~~4.500~~
80156	~~12~~	Plastic (NOC) - Major Surgery	~~4.500~~

80120	4	Urology - Minor Surgery	1.250
80281	5	Cardiovascular Disease - Minor Surgery	1.500
80282	5	Dermatology - Minor Surgery	1.500
80271	5	Diabetes - Minor Surgery	1.500
80272	5	Endocrinology - Minor Surgery	1.500
80421	5	Family Practice, GP (excl. OB) - Minor Surgery	1.500
80274	5	Gastroenterology - Minor Surgery	1.500
80276	5	Geriatrics - Minor Surgery	1.500
80277	5	Gynecology - Minor Surgery	1.500
80278	5	Hematology - Minor Surgery	1.500
80222	5	Hospitalist	1.500
80279	5	Infectious Diseases - Minor Surgery	1.500
80284	5	Internal Medicine - Minor Surgery	1.500
80261	5	Neurology - No Surgery	1.500
80291	5	Otorhinolaryngology - Minor Surgery	1.500
80293	5	Pediatrics - Minor Surgery	1.500
80208	5	Physical & Rehab Med. incl. Pain Mgmt - Minor Procedures	1.500
80294	5	Physician (NOC) - Minor Surgery	1.500
80253	5	Radiology Diagnostic - No Surgery	1.500
80268	5	Urgent Care excl. Emergency Med. - No Surgery	1.500
80145	5	Urology - Major Surgery	1.500
80283	6	Intensive & Critical Care Medicine	1.650
80288	6	Neurology - Minor Surgery	1.650
80292	6	Pathology - Minor Surgery	1.650
80208	6	Physical & Rehab Med. incl. Pain Mgmt - Major Procedures	1.650
80280	6	Radiology Diagnostic - Minor Surgery	1.650
80360	6	Radiology Interventional - including invasive procedures	1.650
80101	7	Broncho-Esophagology - Major Surgery	2.150
80103	7	Endocrinology - Major Surgery	2.150
80104	7	Gastroenterology - Major Surgery	2.150
80105	7	Geriatrics - Major Surgery	2.150
80804	7	Neonatal/Perinatal Medicine	2.150
80108	7	Nephrology - Major Surgery	2.150
80159	7	Otorhinolaryngology excl. Facial Plastic – Major Surgery	2.150
80115	8	Colon & Rectal - Major Surgery	2.500
80164	8	Oncology - Major Surgery	2.500
80117	8	Physician (NOC) - Major Invasive Procedures	2.500
80160	8	Rhinology Surgery	2.500
80102	9	Emergency Medicine - excl. Major Surgery	3.000
80420	9	Family Practice, GP - incl. OB & assist CS	3.000
80143	9	General (NOC) excl. Bariatrics - Major Surgery	3.000
80154	9	Orthopedic excl. Spine - Major Surgery	3.000
80156	9	Plastic (NOC) - Major Surgery	3.000
80169	10	Hand - Major Surgery	3.350
80154	10	Orthopedic incl. Spine - Major Surgery	3.350
80155	10	Otorhinolaryngology incl. Facial Plastic - Major Surgery	3.350
80166	11	Abdominal - Major Surgery	3.750
80157	11	Emergency Medicine - incl. Major Surgery	3.750
80167	11	Gynecology - Major Surgery	3.750
80170	11	Head & Neck - Major Surgery	3.750
80141	12	Cardiac - Major Surgery	4.500
80150	12	Cardiovascular Disease - Major Surgery	4.500
80156	12	Dermatology - Major Surgery	4.500

80144	12	Thoracic - Major Surgery	4.500
80171	12	Traumatic - Major Surgery	4.500
80146	12	Vascular - Major Surgery	4.500
80153	13	OB/GYN - Major Surgery	5.500
80168	13	Obstetrics - Major Surgery	5.500
80152	14	Neurology - Major Surgery	6.750

XVII. PROFESSIONAL ENTITY COVERAGE

A. Solo Practitioner Corporation:

Coverage for an insured's professional entity may be written with a shared limit of liability at no additional charge as long as the entity does not employ any other licensed physicians or surgeons.

B. Shared Limits of Liability:

Coverage for professional entities other than solo practitioners may be written with a shared limit of liability. The charge for shared limits of liability will be 3% of the discounted manual rate, prior to the application of any applicable deductibles, of all insured providers, with the maximum premium limited to a cap of the top 5 highest rated healthcare providers listed of the Declarations and Schedule of Insureds when calculation the premium.

C. Separate Limits of Liability:

Coverage for professional entities may be written with a separate limit of liability. The premium charge for separate limits in which all members, stockholders or employees are insured with Professional Solutions Insurance Company will be 10% of the discounted manual rate, prior to the application of any applicable deductibles, of all insured providers, with the maximum premium limited to a cap of the top 5 highest rated healthcare providers listed on the Declarations and Schedule of Insureds when calculating the premium.

XVIII. MID-LEVEL HEALTHCARE PROVIDER COVERAGE

A. Shared Limits of Liability:

Coverage for licensed, mid-level healthcare providers may be written so the mid-level healthcare providers share a separate limit of liability with another insured as stated on the Schedule of Mid-level Providers. There is no additional premium charge for up to 5 mid-level providers sharing in a separate limit. More than 5 mid-level providers requesting to share in a separate limit will be referred to Underwriting.

B. Separate Limits of Liability:

Coverage for licensed, mid-level healthcare providers is available on an individual, separate limits basis for employees of physicians insured by PSIC.

Mid-Level Healthcare Provider Classification Plan

ISO Specialty Codes	Mid-Level Healthcare Provider	Separate Limit Factor
80998	Other Ancillary Healthcare Provider	0.200
80960	Certified Registered Nurse Anesthetist	0.300
80965	Nurse Practitioner	0.300
80116	Physician Assistant	0.300
80116	Surgeon Assistant	0.300

80144	12	Thoracic - Major Surgery	4.500
80171	12	Traumatic - Major Surgery	4.500
80146	12	Vascular - Major Surgery	4.500
80153	13	OB/GYN - Major Surgery	5.500
80168	13	Obstetrics - Major Surgery	5.500
80152	14	Neurology - Major Surgery	6.750

XVII. PROFESSIONAL ENTITY COVERAGE

A. Solo Practitioner Corporation:

Coverage for an insured's professional entity may be written with a shared limit of liability at no additional charge as long as the entity does not employ any other licensed physicians or surgeons.

B. Shared Limits of Liability:

Coverage for professional entities other than solo practitioners may be written with a shared limit of liability. The charge for shared limits of liability will be 3% of the discounted manual rate, prior to the application of any applicable deductibles, of all insured providers, with the maximum premium limited to a cap of the top 5 highest rated healthcare providers listed of the Declarations and Schedule of Insureds when calculation the premium.

C. Separate Limits of Liability:

Coverage for professional entities may be written with a separate limit of liability. The premium charge for separate limits in which all members, stockholders or employees are insured with Professional Solutions Insurance Company will be 10% of the discounted manual rate, prior to the application of any applicable deductibles, of all insured providers, with the maximum premium limited to a cap of the top 5 highest rated healthcare providers listed on the Declarations and Schedule of Insureds when calculating the premium.

XVIII. MID-LEVEL HEALTHCARE PROVIDER COVERAGE

A. Shared Limits of Liability:

Coverage for licensed, mid-level healthcare providers may be written so the mid-level healthcare providers share a separate limit of liability with another insured as stated on the Schedule of Mid-level Providers. There is no additional premium charge for up to 5 mid-level providers sharing in a separate limit. More than 5 mid-level providers requesting to share in a separate limit will be referred to Underwriting.

B. Separate Limits of Liability:

Coverage for licensed, mid-level healthcare providers is available on an individual, separate limits basis for employees of physicians insured by PSIC.

Mid-Level Healthcare Provider Classification Plan

ISO Specialty Codes	Mid-Level Healthcare Provider	Separate Limit Factor
80998	Other Ancillary Healthcare Provider	0.200
80960	Certified Registered Nurse Anesthetist	0.300
80965	Nurse Practitioner	0.300
80116	Physician Assistant	0.300
80116	Surgeon Assistant	0.300

XVIII. MISCELLANEOUS MEDICAL FACILITIES

Coverage for miscellaneous medical facilities may be written with a separate limit of liability.

Miscellaneous Medical Facility Mature Claims Made Rate (@ 100/300 limits)

Illinois Territory 01 - (Cook, Madison and St. Clair counties)	**$10.94**
Illinois Territory 02 - (DuPage, Kane, Lake, McHenry and Will counties)	**$8.10**
Illinois Territory 03 - (Champaign, Macon, Jackson, Vermillion, Sangamon, DeKalb, Kankakee, LaSalle, Ogle, Randolph, Winnebago and Jackson counties)	**$7.15**
Illinois Territory 04 - (Remainder of State)	**$5.24**

ISO Specialty Codes	Description	Factor
80613	Dialysis Center	0.150 Per Visit
80453	Ambulatory Surgical Center	1.000 Per Surgery
80613	Cancer Treatment Center	0.150 Per Visit
80613	Medical Spa	0.050 Per Visit
80613	Urgent Care	0.200 Per Visit
80715	Laboratory	0.500 Per $1,000 of Receipts
80715	Imaging Facility	0.500 Per $1,000 of Receipts

XX. RATES

Physicians and Surgeons Mature Claims Made Rate (for Class 3 provider @ 100/300 limits)

Illinois Territory 01 - (Cook, Madison and St. Clair counties)	**$10,282.00**
Illinois Territory 02 - (DuPage, Kane, Lake, McHenry and Will counties)	**$7,613.00**
Illinois Territory 03 - (Champaign, Macon, Jackson, Vermillion, Sangamon, DeKalb, Kankakee, LaSalle, Ogle, Randolph and Winnebago counties)	**$6,717.00**
Illinois Territory 04 - (Remainder of State)	**$4,925.00**

XVIII. MISCELLANEOUS MEDICAL FACILITIES

Coverage for miscellaneous medical facilities may be written with a separate limit of liability.

Miscellaneous Medical Facility Mature Claims Made Rate (@ 100/300 limits)

Illinois Territory 01 - (Cook, Madison and St. Clair counties)	**$10.94**
Illinois Territory 02 - (DuPage, Kane, Lake, McHenry and Will counties)	**$8.10**
Illinois Territory 03 - (Champaign, Macon, Jackson, Vermillion, Sangamon, DeKalb, Kankakee, LaSalle, Ogle, Randolph, Winnebago and Jackson counties)	**$7.15**
Illinois Territory 04 - (Remainder of State)	**$5.24**

ISO Specialty Codes	Description	Factor
80613	Dialysis Center	0.150 Per Visit
80453	Ambulatory Surgical Center	1.000 Per Surgery
80613	Cancer Treatment Center	0.150 Per Visit
80613	Medical Spa	0.050 Per Visit
80613	Urgent Care	0.200 Per Visit
80715	Laboratory	0.500 Per $1,000 of Receipts
80715	Imaging Facility	0.500 Per $1,000 of Receipts

XX. RATES

Physicians and Surgeons Mature Claims Made Rate (for Class 3 provider @ 100/300 limits)

Illinois Territory 01 - (Cook, Madison and St. Clair counties)	**$10,282.00**
Illinois Territory 02 - (DuPage, Kane, Lake, McHenry and Will counties)	**$7,613.00**
Illinois Territory 03 - (Champaign, Macon, Jackson, Vermillion, Sangamon, DeKalb, Kankakee, LaSalle, Ogle, Randolph and Winnebago counties)	**$6,717.00**
Illinois Territory 04 - (Remainder of State)	**$4,925.00**

Increase limit factors: The applicable limit factor is determined by the chosen limit option on the application.

Limits of Liability	Increase Limit Factors
$100,000/$300,000	1.000
$200,000/$600,000	1.375
$250,000/$750,000	1.500
$500,000/$1,000,000	1.875
$1,000,000/$3,000,000	2.500
$2,000,000/$4,000,000	3.125

Claims-Made Step Factors:

Year	Claims-Made Step Factor
1	~~0.35~~
2	~~0.66~~
3	~~0.90~~
4	~~0.98~~
Mature	1.00

6th Month Rule: If the period between the retroactive date and the policy effective date is less than 6 months, rate at year 1. If the period is more than 6 months, rate at year 2, with each of the next consecutive claims made step increases applied at each renewal.

Increase limit factors: The applicable limit factor is determined by the chosen limit option on the application.

Limits of Liability	Increase Limit Factors
$100,000/$300,000	1.000
$200,000/$600,000	1.375
$250,000/$750,000	1.500
$500,000/$1,000,000	1.875
$1,000,000/$3,000,000	2.500
$2,000,000/$4,000,000	3.125

Claims-Made Step Factors:

Year	Claims-Made Step Factor
1	0.250
2	0.500
3	0.780
4	0.925
Mature	1.000

6th Month Rule: If the period between the retroactive date and the policy effective date is less than 6 months, rate at year 1. If the period is more than 6 months, rate at year 2, with each of the next consecutive claims made step increases applied at each renewal.

Contact Person:
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Illinois Department of Insurance Review Requirements Checklist

320 West Washington Street
Springfield, IL 62767-0001

Effective as of 8/25/06

Line(s) of Business	Code(s)	
___**MEDICAL MALPRACTICE**	**11.0000**	***This checklist is for rate/rule filings only. See separate form checklist.
___Claims Made	11.10000	
___Occurrence	11.2000	

Line(s) of Insurance	Code(s)	Line(s) of Insurance	Code(s)	Line(s) of Insurance	Code(s)
__Acupuncture	11.0001	___Hospitals	11.0009	___Optometry	11.0019
__Ambulance Services	11.0002	___Professional Nurses	11.0032	___Osteopathy	11.0020
__Anesthetist	11.0031	___Nurse – Anesthetists	11.0010	___Pharmacy	11.0021
__Assisted Living Facility	11.0033	___Nurse – Lic. Practical	11.0011	___Physical Therapy	11.0022
__Chiropractic	11.0003	___Nurse – Midwife	11.0012	___Physicians & Surgeons	11.0023
__Community Health Center	11.0004	___Nurse – Practitioners	11.0013	___Physicians Assistants	11.0024
__Dental Hygienists	11.0005	___Nurse – Private Duty	11.0014	___Podiatry	11.0025
__Dentists	11.0030	___Nurse – Registered	11.0015	___Psychiatry	11.0026
__Dentists – General Practice	11.0006	___Nursing Homes	11.0016	___Psychology	11.0027
__Dentists – Oral Surgeon	11.0007	___Occupational Therapy	11.0017	___Speech Pathology	11.0028
__Home Care Service \gencies	11.0008	___Ophthalmic Dispensing	11.0018	___Other	11.0029

Illinois Insurance Code Link	Illinois Compiled Statutes Online	
Illinois Administrative Code Link	Administrative Regulations Online	
Product Coding Matrix Link	Product Coding Matrix	
NAIC Uniform Transmittal Form	50 IL Adm. Code 929 NAIC Uniform Transmittal Form	If insurers wish to use the NAIC Uniform Transmittal form in lieu of a cover letter/explanatory memorandum, the Department will accept such form, as long as all information required in the "Cover Letter & Explanatory Memorandum" section below are properly included.
NAIC Self-Certification Pilot Program	Newsletter Article regarding Department's Participation Self-Certification form	If an authorized company officer completes the Self-Certification form, and submits such form as the 1st page of the filing, the Department will expedite review of the filing ahead of all other filings received to date. The Department will track company compliance with the laws, regulations, bulletins, and this checklist and report such information to the NAIC.
Location of Standard within Filing Column	See checklist format below.	To expedite review of your filing, use this column to indicate location of the standard within the filing (e.g. page #, section title, etc.)
Description of Review Standards Requirements Column	See checklist format below.	These brief summaries do not include all requirements of all laws, regulations, bulletins, or requirements, so review actual law, regulation, bulletin, or requirement for details to ensure that forms are fully compliant before filing with the Department of Insurance.

FILING			

REQUIREMENTS FOR FORM FILINGS	REFERENCE	DESCRIPTION OF REVIEW STANDARD REQUIREMENT	LOCATION OF STANDARD WITHIN FILING
See separate form filing checklist.		To assist insurers in submitting compliant medical liability rate/rule filings as a result of newly-passed PA94-677 (SB475), the Department has created this separate, comprehensive rate/rule filing checklist for medical liability filings. Please see the separate form filing checklist for requirements related to medical liability forms.	
GENERAL FILING REQUIREMENTS FOR ALL RATE/RULE FILINGS			
LINE OF AUTHORITY			
Must have proper Class and Clause authority to conduct this line of business in Illinois.	215 ILCS 5/4 List of Classes/Clauses	To write Medical Liability insurance in Illinois, companies must be licensed to write: 1. Class 2, Clause (c)	Ok
RATES AND RULES REQUIRED TO BE FILED			
Rates/Rules Must be Filed Separately from Forms			
Insurers shall make separate filings for rate/rules and for forms/endorsements, etc.		The laws and regulations for medical liability forms/endorsements and the laws for medical liability rates/rules are different and each must be reviewed according to its own set of laws/regulations/procedures. Therefore, insurers are required to file forms and rates/rules separately. For requirements regarding form filings, see separate form filing checklist.	Ok
Insurer Filing Requirements			
Insurers must file their rates, rules, plans for gathering statistics, etc. upon commencement of business.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers must file the following: a) Medical liability insurance rate manual, including all rates. b) Rules, including underwriting rule manuals which contain rules for applying rates or rating plans, c) Classifications and other such schedules used in writing medical liability insurance. d) Statement regarding whether the insurer: • Has its own plan for the gathering of medical liability statistics; or • Reports its medical liability statistics to a statistical agent (and if so, which agent). The Director, at any time, may request a copy of the insurer's statistical plan or request the insurer to provide written verification of membership and reporting status from the insurer's reported statistical agency.	N/A

		Insurers are instructed to review all requirements in this checklist, including the requirements for applicable actuarial documentation, as well as all medical liability laws and regulations, to ensure that the filing contains all essential elements before submitting the filing to the Department.	
Amendments to Initial Rate/Rule Filings			
After a new insurer has filed the rates/rules/information described above, insurers must file rates/rules, or advise of changes to statistical plans, as often as they are amended.	215 ILCS 5/155.18 50 IL Adm. Code 929	After a new insurer has filed the rates/rules/information described above, insurers must file rates/rules/rating schedules (as described above for new business) as often as such filings are changed or amended, or when any new rates or rules are added. Any change in premium to the company's insureds as a result of a change in the company's base rates or a change in its increased limits factors shall constitute a change in rates and shall require a filing with the Director. Insurers shall also advise the Director if its plans for the gathering of statistics has changed, or if the insurer has changed statistical agents. The Director, at any time, may request a copy of the insurer's statistical plan or request the insurer to provide written verification of membership and reporting status from the insurer's reported statistical agency. Insurers are instructed to review all requirements in this checklist, including the requirements for applicable actuarial documentation, as well as all medical liability laws and regulations, to ensure that the filing contains all essential elements before submitting the filing to the Department.	Ok
EFFECTIVE DATES OF RATE/RULE FILINGS			
Illinois is "file and use" for medical liability rates and rules.	215 ILCS 5/155.18 50 IL Adm. Code 929	A rate/rating plan/rule filing shall go into effect no earlier than the date the filing is received by the Department of Insurance, Property & Casualty Compliance Section, except as otherwise provided in Section 155.18.	Ok
ADOPTIONS OF ADVISORY ORGANIZATION FILINGS			
Insurer must file all rates and rules on its own behalf.	50 IL Adm. Code 929	Although Rule 929 allows for insurers to adopt advisory organization rule filings, advisory organizations no longer file rules in Illinois.	Ok
COPIES, RETURN ENVELOPES, ETC.			
Requirement for duplicate copies and return envelope with adequate postage.	50 IL Adm. Code 929	Insurers that desire a stamped returned copy of the filing or submission letter must submit a duplicate copy of the filing/letter, along with a return envelope large enough and containing enough postage to accommodate the return filing.	Ok
COVER LETTER & EXPLANATORY MEMORANDUM			

Two copies of a submission letter are required, and the submission letter must contain the information specified. "Me too" filings are not allowed. Use of NAIC Uniform Transmittal form is acceptable as long as all required information is included.	215 ILCS 5/155.18 50 IL Adm. Code 929 Company Bulletin 88-53 Actuarial Certification Form NAIC Uniform Transmittal Form	All filings must be accompanied by a submission letter which includes all of the following information: 1) Exact name of the company making the filing. 2) Federal Employer Identification Number (FEIN) of the company making the filing. 3) Unique filing identification number – may be alpha, numeric, or both. Each filing number must be unique within a company and may not be repeated on subsequent filings. If filing subsequent revisions to a pending filing, use the same filing number as the pending filing or the revision(s) will be considered a new filing. 4) Identification of the classes of medical liability insurance to which the filing applies (for identifying classes, refer to Lines of Insurance shown on Page 1 of this checklist, in compliance with the NAIC Product Coding Matrix). 5) Notification of whether the filing is new or supersedes a present filing. If filing supersedes a present filing, insurer must identify all changes in superseding filings, and all superseded filings, including the following information: • Copy of the complete rate/rule manual section(s) being changed by the filing with all changes clearly highlighted or otherwise identified. • Written statement that all changes made to the superseded filing have been disclosed. • List of all pages that are being completely superseded or replaced with new pages. • List of pages that are being withdrawn and not being replaced. • List of new pages that are being added to the superseded filing. • Copies of all manual pages that are affected by the new filing, including but not limited to subsequent pages that are amended solely by receiving new page numbers. 6) Effective date of use. 7) Actuarial certification (see Actuarial Certification section below). Insurers may use their own form or may use the sample form developed by the Department. 8) Statement that the insurer, in offering, administering, or applying the filed rate/rule manual and/or any amended provisions, does not unfairly discriminate. Companies under the same ownership or general management are required to make separate, individual company filings. Company Group ("Me too") filings are unacceptable. If insurers wish to use the NAIC Uniform Transmittal form in lieu of a cover letter/explanatory memorandum, the Department will accept such form, as long as all information required in this section is properly included.	Ok

FORM RF-3 Summary Sheet			
For any rate change, duplicate copies of Form RF-3 must be filed, no later than the effective date.	50 IL Adm. Code 929 Form RF-3 Summary Sheet	For any rate level change, insurers must file two copies of Form RF-3 (Summary Sheet) which provides information on changes in rate level based on the company's premium volume, rating system, and distribution of business with respect to the classes of medical liability insurance to which the rate revision applies. Such forms must be received by the Department's Property & Casualty Compliance Section no later than the stated effective date of use. Insurers must report the rate change level and premium volume amounts on the "Other" Line and insert the words "Medical Liability" on the "Other" descriptive line. Do not list the information on the "Other Liability" line. If the Medical Liability premium is combined with any other Lines of Business (e.g. CGL, commercial property, etc.), the insurer must report the effect of rate changes to each line separately on the RF-3, indicating the premium written and percent of rate change for each line of business. The RF-3 form must indicate whether the information is "exact" or "estimated."	See RF-3
PAYMENT PLANS			
Quarterly premium payment installment plan required as prescribed by the Director.	215 ILCS 5/155.18	A company writing medical liability insurance in Illinois shall offer to each of its medical liability insureds the option to make premium payments in quarterly installments as prescribed by and filed with the Director. Such option must be offered in the initial offer of the policy or in the first policy renewal occurring after January 1, 2006. Thereafter, the insurer need not offer the option, but if the insured requests it, must make it available. Such plans are subject to the following minimum requirements: • May not require more than 40% of the estimated total premium to be paid as the initial payment; • Must spread the remaining premium equally among the 2nd, 3rd, and 4th installments, with the maximum set at 30% of the estimated total premium, and due 3, 6, and 9 months from policy inception, respectively; • May not apply interest charges; • May include an installment charge or fee of no more than the lesser of 1% of the total premium or $25; • Must spread any additional premium resulting from changes to the policy equally over the remaining installments, if any. If there are no remaining installments, the additional premium may be billed immediately as a separate transaction; and • May, but is not required to offer payment plan for extensions of a reporting period, or to insureds whose annual premiums are less than $500. However, if offered to either, the plan must be	Section VII

		made available to all within that group.	
DEDUCTIBLES			
Deductible plans should be filed if offered.	215 ILCS 5/155.18	A company writing medical liability insurance in Illinois is encouraged, but not required, to offer the opportunity for participation in a plan offering deductibles to its medical liability insureds. Any such plan shall be contained in a filed rate/rule manual section entitled "Deductibles Offered" or substantially similar title. If an insurer uses a substantially similar title, the Rate/Rule Submission Letter or NAIC Uniform Transmittal form must indicate the name of the section that applies.	Section XIV
DISCOUNTS			
Premium discount for risk management activities should be filed if offered.	215 ILCS 5/155.18	A company writing medical liability insurance in Illinois is encouraged, but not required, to offer their medical liability insureds a plan providing premium discounts for participation in risk management activities. Any such plan shall be contained in a filed rate/rule manual section entitled "Risk Management Activities Discounts" or substantially similar title. If an insurer uses a substantially similar title, the Rate/Rule Submission Letter or NAIC Uniform Transmittal form must indicate the name of the section that applies.	Section XII
CLAIMS MADE REQUIREMENTS			
Extended reporting period (tail coverage) requirements.	215 ILCS 5/143(2) Company Bulletin 88-50	When issuing claims-made medical liability insurance policies, insurers must include the following specific information in their rate/rule manuals: • Offer of an extended reporting period (tail coverage) of at least 12 months. The rate/rule manual must specify whether the extended reporting period is unlimited or indicate its term (i.e. number of years).*** • Cost of the extended reporting period, which must be priced as a factor of one of the following:*** o the last 12 months' premium. o the premium in effect at policy issuance. o the expiring annual premium. • List of any credits, discounts, etc. that will be added or removed when determining the final extended reporting period premium. • Insurer will inform the insured of the extended reporting period premium at the time the last policy is purchased. The insurer may not wait until the insured requests to purchase the extended reporting period coverage to tell the insured what the premium will be or how the premium would be calculated. • Insurer will offer the extended reporting period when the policy is terminated for any reason, including non-payment of premium, and whether the policy is terminated at the company's or insured's request. • Insurer will allow the insured 30 days after the policy is terminated to purchase the extended reporting period coverage.***	Section IX

		***If the medical liability coverage is combined with other professional or general liability coverages, the medical liability insurer must meet all of the above requirements, except those indicated with ***, in which case, the insurer must: • Offer free 5-year extended reporting period (tail coverage) or • Offer an unlimited extended reporting period with the limits reinstated (100% of aggregate expiring limits for the duration) • Cap the premium at 200% of the annual premium of the expiring policy; and • Give the insured a free-60 day period after the end of the policy to request the coverage.	
GROUP MEDICAL LIABILITY			
Group medical liability insurance is not specifically allowed under the Illinois Insurance Code.	50 IL Adm. Code 906	Part 906 of the Illinois Administrative Code prohibits writing of group casualty (liability) insurance unless specifically authorized by statute. The Illinois Insurance Code does not specifically authorize the writing of group medical liability insurance.	N/A
CANCELLATION & NONRENEWAL PROVISION REQUIREMENTS			
If rate/rule manuals contain language pertaining to cancellation or nonrenewal, must comply with all cancellation/nonrenewal laws.	See Medical Liability Forms Checklist for Specific Information about Illinois Cancellation & Nonrenewal Laws and Regulations,	If a rate or rule manual contains language pertaining to cancellation or nonrenewal of any medical liability insurance coverage, such provisions must comply with all cancellation and nonrenewal provisions of the Illinois Insurance Code, including but not limited to the following: 143.10, 143.16, 143.16a, 143.17a. See Medical Liability Forms Checklist for Specific Information about Illinois Cancellation & Nonrenewal Laws and Regulations,	Section VI
ACTUARIAL REVIEW REQUIREMENTS			
Rates shall not be excessive, inadequate, or unfairly discriminatory.	215 ILCS 5/155.18	In the making or use of rates pertaining to all classes of medical liability insurance, rates shall not be excessive, or inadequate, nor shall they be unfairly discriminatory. Rate and rule manual provisions should be defined and explained in a manner that allows the Department to ascertain whether the provision could be applied in an unfairly discriminatory manner. For example, if a rate/rule manual contains ranges of premiums or discounts, the provision must specify the criteria to determine the specific premium/discount an insured or applicant would receive. The Director may, by order, adjust a rate or take any other appropriate action at the conclusion of a public hearing.	Ok
PRICING			
Insurers shall consider certain information when developing medical liability rates.	215 ILCS 5/155.18	Consideration shall be given, to the extent applicable, to past and prospective loss experience within and outside this State, to a reasonable margin for underwriting profit and contingencies, to past and prospective expenses both countrywide and those especially applicable to Illinois, and to all other factors,	Ok

		including judgment factors, deemed relevant within and outside Illinois. Consideration may also be given in the making and use of rates to dividends, savings or unabsorbed premium deposits allowed or returned by companies to their policyholders, members or subscribers. The systems of expense provisions included in the rates for use by any company or group of companies may differ from those of other companies or groups of companies to reflect the operating methods of any such company or group with respect to any kind of insurance, or with respect to any subDepartment or combination thereof.	
Minimum Premium Rules			
Insurers may group or classify risks for establishing rates and minimum premiums.	215 ILCS 5/155.18	Risks may be grouped by classifications for the establishment of rates and minimum premiums.	N/A
"A" RATED RISKS			
Individual Risk Rating			
Risks may be rated on an individual basis as long as all provisions required in Section 155.18 are met.	215 ILCS 5/155.18	Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any difference among risks that have a probable effect upon losses or expenses. Such classifications or modifications of classifications of risks may be established based upon size, expense, management, individual experience, location or dispersion of hazard, or any other reasonable considerations, and shall apply to all risks under the same or substantially the same circumstances or conditions. The rate for an established classification should be related generally to the anticipated loss and expense factors or the class.	N/A
RISK CLASSIFICATION			
Risks may be grouped by classifications.	215 ILCS 5/155.18	Risks may be grouped by classifications for the establishment of rates and minimum premiums.	N/A
Rating decisions based solely on domestic violence.	215 ILCS 5/155.22b	No insurer may that issues a property and casualty policy may use the fact that an applicant or insured incurred bodily injury as a result of a battery committed against him/her by a spouse or person in the same household as a sole reason for a rating decision.	N/A
Unfair methods of competition or unfair or deceptive acts or practices defined.	215 ILCS 5/424(3)	It is an unfair method of competition or unfair and deceptive act or practice if a company makes or permits any unfair discrimination between individuals or risks of the same class or of essentially the same hazard and expense element because of the race, color, religion, or national origin of such insurance risks or applicants.	N/A
Procedure as to unfair methods of competition or unfair or deceptive acts or practices not defined.	215 ILCS 5/429	Outlines the procedures the Director follows when he has reason to believe that a company is engaging in unfair methods of competition or unfair or deceptive acts or practices.	N/A
Territorial Definitions			

Rate/rule manuals must contain correct and adequate definitions of Illinois territories.	215 ILCS 5/155.18	When an insurer's rate/rule program includes differing territories within the State of Illinois, rate/rule manuals must contain correct and adequate definitions of those territories, and that all references to the territories or definitions are accurate, so the Department does not need to request additional information.	Section XX
ACTUARIAL SUPPORT INFORMATION REQUIRED			
ACTUARIAL CERTIFICATION			
Actuarial certification must accompany all rate filings and all rule filings that affect rates.	215 ILCS 5/155.18 50 IL Adm. Code 929 Actuarial Certification Form	Every rate and/or rating rule filing must include a certification by an officer of the company and a qualified actuary that the company's rates and/or rules are based on sound actuarial principles and are not inconsistent with the company's experience. Insurers may use their own form or may use the sample form created by the Department.	See Certification
ACTUARIAL OR STATISTICAL INFORMATION			
Director may request actuarial and statistical information.	215 ILCS 5/155.18 50 IL Adm. Code 929	The Director may require the filing of statistical data and any other pertinent information necessary to determine the manner of promulgation and the acceptability or unacceptability of a filing for rules, minimum premiums, rates, forms or any combination thereof. If the Director requests information or statistical data to determine the manner the insurer used to set the filed rates and/or to determine the reasonableness of those rates, as well as the manner of promulgation and the acceptability or unacceptability of a filing for rules, minimum premiums, or any combination thereof, the insurer shall provide such data or information within 14 calendar days of the Director's request.	Ok
Explanatory Memorandum			
Insurers shall include actuarial explanatory memorandum with any rate filing, as well as any rule filing that affects the ultimate premium.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include actuarial explanatory memorandum with any rate filing, as well as any rule filing that affects the ultimate premium. The explanatory memorandum shall contain, at minimum, the following information: • Explanation of ratemaking methodologies. • Explanations of specific changes included in the filing. • Narrative that will assist in understanding the filing.	See Actuarial Analysis
Summary of Effects Exhibit			
Insurers shall include an exhibit illustrating the effect of each change and calculation indicating how the final effect was derived.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include an exhibit illustrating the effect of each individual change being made in the filing (e.g. territorial base rates, classification factor changes, number of exposures affected by each change being made, etc.), and include a supporting calculation indicating how the final effect was derived.	See Actuarial Analysis
Actuarial Indication			
Insurers shall include actuarial support	215 ILCS 5/155.18	Insurers shall include actuarial support justifying the overall changes being made, including but not limited	See Actuarial Analysis

justifying the overall changes being made.	50 IL Adm. Code 929	to: • Pure premiums (if used). • Earned premiums. • Incurred losses. • Loss development factors. • Trend factors. • On-Level factors. • Permissible loss ratios, etc.	
Loss Development Factors and Analysis			
Insurers shall include support for loss development factors and analysis.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include actuarial support for loss development factors and analysis, including but not limited to loss triangles and selected factors, as well as support for the selected factors.	See Actuarial Analysis
Ultimate Loss Selections			
Insurers shall include support for ultimate loss selections.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include support for ultimate loss selections, including an explanation of selected losses if results from various methods differ significantly.	See Actuarial Analysis
Trend Factors and Analysis			
Insurers shall include support for trend factors and analysis.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include support for trend factors and analysis, including loss and premium trend exhibits demonstrating the basis for the selections used.	See Actuarial Analysis
On-Level Factors and Analysis			
Insurers shall include support for on-level factors and analysis.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include support for on-level factors and analysis, including exhibits providing on-level factors and past rate changes included in calculations.	See Actuarial Analysis
Loss Adjustment Expenses			
Insurers shall include support for loss adjustment expenses.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include support for loss adjustment expenses, including exhibits providing documentation to support factors used for ALAE and ULAE. If ALAE is included in loss development analysis, no additional ALAE exhibit is required.	See Actuarial Analysis
Expense Exhibit			
Insurers shall include an expense exhibit. Insurers may use expense provisions that differ from those of other companies or groups of companies.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include an exhibit indicating all expenses used in the calculation of the permissible loss ratio, including explanations and support for selections. The systems of expense provisions included in the rates for use by any company or group of companies may differ from those of other companies or groups of companies to reflect the operating methods of any such company or group with respect to any kind of insurance, or with respect to any subDepartment or combination thereof.	N/A
Investment Income Calculation			
Insurers shall include an exhibit for investment income calculation.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include an exhibit demonstrating the calculation for the investment income factor used in the indication.	N/A
Profit and Contingencies			

Calculation			
Insurers shall include an exhibit for profit and contingencies load.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include an exhibit illustrating the derivation of any profit and contingencies load.	N/A
Credibility Standard Used			
Insurers shall include the number of claims being used to calculate the credibility factor.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers should include the number of claims being used to calculate the credibility factor. If another method of calculating credibility is utilized, insurers should include a description of the method used.	See Actuarial Analysis
Other Actuarial Information Required			
Insurers must include the information described in this section.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall also include the following information: • All actuarial support/justification for all rates being changed, including but not limited to changes in: ○ Base rates; ○ Territory definitions; ○ Territory factor changes; ○ Classification factor changes; ○ Classification definition changes; ○ Changes to schedule credits/debits, etc. • Exhibits containing current and proposed rates/factors for all rates and classification factors, etc. being changed. • Any exhibits necessary to support the filing that are not mentioned elsewhere in this checklist.	See Actuarial Analysis
Schedule Rating			
Insurers must include the described information described at right.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers should include appropriate actuarial justification when filing schedule rating plans and/or changes to schedule rating plans.	N/A

PROFESSIONAL SOLUTIONS INSURANCE COMPANY

STATE OF ILLINOIS

PHYSICIANS AND SURGEONS

MEDICAL PROFESSIONAL LIABILITY MANUAL

CLAIMS MADE COVERAGE

I. APPLICATION OF THIS MANUAL-ELIGIBILITY

This claims made program covers Physicians and Surgeons engaged in the rendering of professional services specific to their disciplines. Refer to the classification plan for a description of each risk/rating category for physicians and surgeons.

Employees of health care professionals are also included as insureds for their acts while performing duties within the scope of their discipline while under the direction and supervision of the insured named in the coverage summary. Refer to the listing of the mid-level healthcare providers who may be covered by either a shared or separate limit of liability.

This program also provides coverage for both medical clinics and individual practicing physicians for the liability exposure of a partnership, corporation or professional association on either a separate or shared limit basis. Refer to the professional entity coverage section for a description of the partnership, corporation or professional association rating factors.

II. PREMIUM DETERMINATION

1. Determine the manual rate for the appropriate territory.
2. Refer to Classification Listing and apply the factor for the appropriate class specialty being rated.
3. Apply the appropriate increase limit factor.
4. Apply the appropriate claims made step factor to reach the undiscounted premium.
5. .Apply discounts, as appropriate, for part-time or new practitioner.
6. Apply any applicable credits/debits for experience rating.
7. Apply any applicable credits/debits for schedule rating.
8. Apply the deductible credit, if applicable.
9. Apply rounding.
10. Example Premium Calculation:

    Assume the full time undiscounted premium is $1,000 and no new practitioner or part-time status applies. Additional credits or debits will be applied in consecutive order.

    $1,000 x .95 = $950.00 (Claims Free credit of 5%)
    $950.00 x .95 = $902.50 (Schedule Rating credit of 5%)
    $902.50 = $903.00 (Apply rounding)

III. POLICY PERIOD

The policy period shall be for a one-year term. Insureds added or removed mid-term will be pro-rated.

IV. WHOLE DOLLAR PREMIUM RULE

All premiums shown on the policy and endorsements shall be rounded to the nearest whole dollar. If the premium is .50 or greater, round to next higher whole dollar. If the premium is .49 or less, round down. In the event of cancellation, the return premium shall be rounded to the nearest whole dollar. Rounding is the last step of the premium calculation.

Example: $1,234.30 is rounded to $1,234.
$1,234.60 is rounded to $1,235.

V. PRACTICE LOCATION

The following parameters will be applied for healthcare providers who practice in multiple territories or states:

A. For healthcare providers classified as No Surgery or Minor Surgery, the location of the primary office practice will determine the manual rate.
B. For healthcare providers classified as Anesthesiology, Intensive Care/Critical Care Medicine, Pathology, Radiology or Major Surgery, the location of the primary healthcare facility practice will determine the manual rate.

C. If a healthcare provider practices equally in two or more states or territories, the rate from the highest territory or state will be applied.

For the purposes of this section, primary means 51% or more of the healthcare provider's practice time is spent in the given territory or state.

The insured must be licensed in all states where practicing.

VI. POLICY CANCELLATION

A. Cancellation By the Insured

The insured may cancel the policy by mailing or delivering notice to the Company stating when such cancellation shall be effective.

This policy will remain in full force and effect until its regular anniversary date unless the policy is cancelled sooner by the Company in accordance with the laws of the State of Illinois.

If the insured cancels the policy, earned premium shall be computed in accordance with the standard short rate tables and procedure. If the Company cancels the policy, earned premium shall be computed pro rata.

B. Cancellation/Non-Renewal By the Company

The Company may cancel or non-renew the policy in accordance with the insurance laws of the State of Illinois. Standard cancellation notice will be sent sixty (60) days prior to cancellation, except that in the event of non-payment of premium, then not less than ten (10) days prior notice will be given.

VII. PREMIUM PAYMENT OPTIONS

1.	Annual	
2.	Semi-Annual	50% prepayment required
3.	Quarterly	25% prepayment required as the initial down payment with remaining payments of 25% each due at 3, 6 & 9 months after policy inception

There is no installment fee charge or interest charged for utilizing the premium payment options. Additional premiums for policy changes occurring during the current policy term shall be computed pro rata of the annual premium. If there are no remaining installments, additional premium resulting from changes in coverage may be due immediately as a separate transaction. If the policy is issued with a final fully discounted premium less than $500, the policy must be billed on an annual basis.

VIII. RENEWALS

The policy will be renewed upon receipt of the required premium on or before the date of each successive policy period. The renewal premium shall be based on rates in effect on the renewal or anniversary date. The applicable forms and endorsements must be made a part of the policy. Additional premiums for policy changes occurring during the current policy term shall be computed pro rata of the annual premium.

IX. SPECIAL PROVISIONS

A. Retroactive Coverage

This extension covers incidents which occurred subsequent to the prior carrier's retroactive date, but which are neither known nor reported as of the inception date of the replacement coverage written by Professional Solutions Insurance Company. The insured may apply for a Retroactive Date that is equal to the retroactive date shown on the previous policy.

Premium for this extension is derived by rating the policy based upon the claims made step factor determined by using the previous carrier's retroactive date.

B. Automatic Reporting Extension

This provision applies when coverage under the policy ends, either by action of the insured or the Company through cancellation, termination or non-renewal.

Under the circumstances stated above, the Company will provide a thirty (30) day Automatic Reporting Extension which allows claims to be reported during this time that result from incidents that happened during the time the coverage was in force. The thirty (30) day Automatic Reporting Extension does not apply if the insured purchases any subsequent insurance that replaces in whole or in part the coverage provided by this policy.

Within thirty (30) days of when the policy coverage terminates, the Company must advise the insured of the availability of Extended Reporting Coverage, the premium cost, and the importance of buying this additional coverage extension, commonly called "Tail Coverage".

The insured will have the greater of sixty (60) days from the date the coverage is terminated, or thirty (30) days from the date of notice, to accept the Extended Reporting Coverage in writing.

C. Extended Reporting Coverage, also called Tail Coverage

Extended Reporting Coverage will be provided for an unlimited time period with aggregate liability limits equal to or less than those of the expired coverage to report claims which arose from incidents that occurred when the coverage was in force. The liability limits provided by this option are the only limits that shall be applicable to the unlimited time period designated above. Extended Reporting Coverage can be applied to individual or entity policies.

The following factors will be applied to the expiring annual premium:

# of Years Completed in Claims Made Program	Tail Factor
1	3.680
2	2.860
3	2.179
4	2.022
5+	1.870

Professional Solutions Insurance Company cannot cancel the Extended Reporting Coverage except for non-payment of the additional premium. Premium is due in full at the time of purchase; no payment plans will be offered.

The Company provides Extended Reporting Coverage automatically, at no additional charge, in the event that the insured dies or becomes permanently disabled.

The Company also provides Extended Reporting Coverage automatically, at no additional charge, in the event the insured retires at or after age fifty-five (55) and after having been continuously insured with Professional Solutions Insurance Company under a claims made policy for five (5) years. The Extended Reporting Coverage premium will be discounted for Insureds who retire at or after age fifty-five (55) with fewer than five (5) years of continuous coverage as follows:

# of Years of Continuous Coverage	Extended Reporting Coverage Credit
1 full year	20%
2 full years	40%
3 full years	60%
4 full years	80%

D. Change in Rating Classification

In the event of a change in exposure or medical specialty of the practitioner, a premium charge reflecting the difference between the previous and such new exposure or specialty shall be calculated and collected at the time of such change unless:

1. otherwise eligible for Extended Reporting Coverage at no additional charge;
2. with regard to medical specialty, both the prior and the current specialty fall within the same class;
3. the exposure or medical specialty of the practitioner changed more than 4 years prior while insured under claims made coverage; or
4. the exposure or medical specialty of the practitioner changed while insured under occurrence coverage.

E. Locum Tenens

Locum Tenens working in the place of an insured shall be provided coverage at no additional premium, for a period not to exceed sixty (60) days per policy term. A completed application must be submitted to the Company for prior underwriting approval.

X. DISCOUNTS

A. New Practitioner

A new practitioner is defined as a person who has completed his or her training, whose only contact with patients has been in the course of his or her training, and who has not been previously insured by Professional Solutions Insurance Company.

1st year	50% credit
2nd year	30% credit
3rd year	10% credit

Those who receive a new practitioner credit will not be eligible to receive any further credits, except for schedule rating and the experience rating modification. The total of all new practitioner and schedule rating credits will not exceed 50%.

B. Part-Time Practitioner

A practitioner must practice 20 hours or less per week to become eligible for this credit. Surgery classes are not eligible for the part-time credit. The insured must complete an application for part-time credit. If the application is approved, credits will be given by year according to the following schedule:

1st year	30% credit
2nd year	40% credit
3rd year	50% credit

Those who receive a part-time practitioner credit will not be eligible to receive any further credits, except for schedule rating and the experience rating modification. The total of all part-time practitioner and schedule rating credits will not exceed 50%.

XI. EXPERIENCE RATING

Claims free credits

A claim is defined as a claim closed with incurred indemnity equal to or greater than $10,000.00 or allocated loss adjustment expense (ALAE) payments plus any Company established reserves for loss or ALAE exceeding $100,000.

A claim free credit shall apply if the insured has achieved at least 3 years without a claim.

The following schedule will apply:

3 yrs	5%
4 yrs	10%
5+ yrs	15%

XII. SCHEDULE RATING

Professional Solutions Insurance Company will use the following schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of Professional Solutions Insurance Company uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

The premium for a risk may be modified in accordance with the following, subject to a maximum modification of a 25% credit to a 25% debit to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule rating plan are subject to periodic review. The actual determination of the appropriate credit or debit will be determined through the underwriting review of the applicant's application.

SCHEDULE RATING PROGRAM		Maximum Credit	Maximum Debit
Historical Loss Experience (Not applicable to insureds receiving Experience Rating Modification)	The frequency or severity of claims for the insured(s) is greater/less than expected experience for an insured(s) of the same classification/size or recognition of unusual circumstances of claims in the loss experience.	N/A	25%
Cumulative Years of Patient Experience	The insured(s) demonstrates a stable, longstanding practice and/or significant degree of experience in their current area of medicine.	10%	10%
Classification Anomalies	Characteristics of a particular insured that differentiate the insured from other members of the same class, or recognition of a recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.	25%	25%
Claims Anomalies	Economic, societal or jurisdictional changes or trends that will influence the frequency or severity of claims, or unusual circumstances of a claim(s) which understate/overstate the severity of the claims(s).	10%	10%
Management Control Procedures	Specific operational activities undertaken by the insured to reduce the frequency and/or severity of claims.	10%	10%
Number/Type of Patient Exposures	Size and/or demographics of the patient population which influences the frequency and/or severity of claims.	10%	10%
Organizational Size / Structure	The organization's size and processes are such that economies of scale are achieved while servicing the insured.	10%	10%
Medical Standards, Quality & Claim Review	Presence of (1) committees that meet on a routine basis to review medical procedures, treatments, and protocols and then assist in the integration of such into the practice, (2) Committees meet to assure the quality of the health care services being rendered and/or (3) Committees to provide consistent review of claims/incidents that have occurred and developed corrective action.	10%	10%
Other Risk Management Practices and Procedures	Additional activities undertaken with specific intention of reducing the frequency or severity of claims.	10%	10%

Training, Accreditation & Credentialing	The insured(s) exhibits greater/less than normal participation and support of such activities.	10%	10%
Record – Keeping Practices	Degree to which insured incorporates methods to maintain quality patient records, referrals, and test results	10%	10%
Utilization of Monitoring Equipment, Diagnostic Tests or Procedures	Demonstrating the willingness to expend the time and capital to incorporate the latest advances in medical treatment and equipment into the practice, or failure to meet accepted standards of care.	10%	10%

XIII. EXPERIENCE RATING MODIFICATION

A. Eligibility

This experience rating plan may apply to a group policy of five or more practitioners with total manual premium of at least $250,000.

B. Application

The experience modification developed according to this rule will apply to the otherwise applicable premium generated for the group, reflecting the applicable limits of liability and any other rating factors, discounts, or surcharges that may apply. The experience modification factor will be applied prior to the application of any deductible credit. The experience modification factor will apply to premium at time of policy issuance or renewal, as well as to the premium associated with any subsequent policy modification during the policy term.

C. Experience Used

To the extent that it is available, a five-year experience period for each individual member and the corporation/partnership will be used to calculate the group's experience modification under this plan. In no instance will less than three years' experience be utilized. The prior years' experience will be compiled by report year. The experience period will start with the second prior policy period, and end with the sixth prior policy period. The experience period ending immediately before the policy period to which the modification will apply is excluded from the experience period.

Experience of the group related to policy periods during which the entity was not covered by Professional Solutions Insurance Company will be included in the experience modification calculations to the extent such prior experience is considered to be complete and accurate.

D. Experience Period Premium Subject to Experience Rating

The development of the Experience Period Premium Subject to Experience Rating (Subject Premium) is as follows:

First, for each year in the experience period, the premium at present rate level is calculated. This calculation involves rating the group's historical exposures in each experience period using the current rates and rating plan factors. The experience period premium at present rates should reflect the $200,000 policy limit underlying this experience rating plan, as well as any discounts, surcharges or other rating factors that are currently applicable, with the exception of any deductible credit. The claims-made step factor used in developing the premiums for each experience period should be consistent with the claim history provided. For example, if a physician's retroactive date implies a second year claims-made policy exposure, but a longer-term history of claims is available, then the retroactive date should be adjusted to reflect the more mature claims experience.

The next step in the development of Subject Premium is to adjust the premiums at present rates to reflect claim cost inflation. The calculation involves de-trending the experience period premiums at present rates from the current claim cost level to the experience period claim cost level.

E. Experience Period Losses Subject to Experience Rating

The development of the Experience Period Losses Subject to Experience Rating (Subject Losses) is as follows:

All claims, open, closed, loss only, loss expense only, paid or reserved, are included for purposes of determining the Experience Modification Factor. Actual claims from each year in the experience period are compiled. Claims are compiled by report year/policy period. In each case, incurred to date loss values (i.e., paid indemnity plus outstanding reserves) are capped at $200,000 per claim and allocated loss adjustment expenses are included in full. The sum of the limited indemnity and unlimited ALAE is then limited to the maximum single loss of $300,000 (limited loss and ALAE).

The next step in the development of the Subject Losses is to include a factor to reflect losses which are "Incurred But Not Reported", or IBNR. IBNR factors are applied to the expected losses (Subject Premium x Expected Loss and ALAE Ratio) for each policy year in the experience period.

The Subject Losses are the sum of the actual limited losses and ALAE and IBNR.

F. Valuation Date

All of the losses for the experience period should be valued as of 6 months prior to the issuance/renewal date. This date will be referred to as the "valuation date".

G. Actual Experience Loss Ratio

The Actual Experience Loss Ratio (AELR) is determined by dividing the Experience Period Subject Losses by the Experience Period Subject Premium.

H. Expected Loss Ratio

The Expected Loss Ratio (ELR) for the group is equal to the state-specific individual physician expected loss ratio adjusted to reflect group underwriting expense savings.

I. Credibility

The credibility will be calculated by taking the square root of the following fraction:

$$\frac{\text{Experience Period Base Class Equivalent Exposures}}{2{,}700}$$

The base class equivalent exposures are calculated as the total Experience Rating Subject Premium divided by the current mature claims-made base rate at $200,000 policy limits. The maximum credibility a risk may receive is 100%. If a risk receives less than 100% credibility, the remaining credibility (100% - actual credibility) is given to unity (i.e., no debit and no credit).

J. Experience Modification Factor

The experience modification factor for the working layer of premium (first $200,000/$600,000 policy limits premium) is calculated as follows:

$$\text{Experience Modification Factor} = [\ \text{AELR/ELR} - 1\ ] \times \text{Credibility} + 1$$

The experience modification factor for the excess layer of premium will equal the square root of the working layer factor.

A final Combined Experience Modification Factor is then determined by applying the experience modifications by layer. The Combined Experience Modification Factor is applicable to the premium gross of deductible.

XIV. DEDUCTIBLE

The insured may elect to pay a deductible towards the amount paid to claimants as damages. The deductible will be collected after the payment of the claim. The following credits apply to the discounted premium.

Policy Limits	Per-Claim with Per-Insured Aggregate Deductible (Loss Only)				
	$5K/$15K	$10K/$30K	$15K/$45K	$20K/$60K	$25K/$75K
$100,000 / $300,000	0.962	0.938	0.913	0.889	0.867
$200,000 / $600,000	0.972	0.953	0.935	0.916	0.900
$250,000 / $750,000	0.974	0.957	0.940	0.923	0.907
$500,000 / $1,000,000	0.979	0.965	0.951	0.938	0.925
$1,000,000 / $3,000,000	0.983	0.972	0.961	0.950	0.940
$2,000,000 / $4,000,000	0.986	0.977	0.968	0.959	0.951

Policy Limits	Per-Claim with Per-Insured Aggregate Deductible (Loss Only)				
	$50K/$150K	$100K/$300K	$200K/$600K	$250K/$750K	$500K/$1.5M
$100,000 / $300,000	0.802	0.680	N/A	N/A	N/A
$200,000 / $600,000	0.851	0.759	0.632	N/A	N/A
$250,000 / $750,000	0.863	0.778	0.661	0.599	N/A
$500,000 / $1,000,000	0.889	0.820	0.725	0.675	0.588
$1,000,000 / $3,000,000	0.911	0.856	0.780	0.740	0.670
$2,000,000 / $4,000,000	0.927	0.882	0.820	0.788	0.731

Policy Limits	Per-Claim No Aggregate Deductible (Loss Only)				
	$5K	$10K	$15K	$20K	$25K
$100,000 / $300,000	0.954	0.926	0.896	0.867	0.847
$200,000 / $600,000	0.966	0.944	0.922	0.899	0.885
$250,000 / $750,000	0.969	0.948	0.928	0.908	0.893
$500,000 / $1,000,000	0.975	0.958	0.941	0.926	0.914
$1,000,000 / $3,000,000	0.980	0.966	0.953	0.940	0.931
$2,000,000 / $4,000,000	0.983	0.972	0.962	0.951	0.944

Policy Limits	Per-Claim No Aggregate Deductible (Loss Only)				
	$50K	$100K	$200K	$250K	$500K
$100,000 / $300,000	0.782	0.680	N/A	N/A	N/A
$200,000 / $600,000	0.836	0.740	0.632	N/A	N/A
$250,000 / $750,000	0.849	0.760	0.641	0.599	N/A
$500,000 / $1,000,000	0.878	0.806	0.709	0.662	0.588
$1,000,000 / $3,000,000	0.902	0.844	0.767	0.730	0.663
$2,000,000 / $4,000,000	0.920	0.873	0.809	0.780	0.726

Policy Limits	Per-Insured Aggregate Deductible (Loss Only)				
	$5K	$10K	$15K	$20K	$25K
$100,000 / $300,000	0.982	0.967	0.948	0.927	0.916
$200,000 / $600,000	0.986	0.975	0.961	0.944	0.937
$250,000 / $750,000	0.988	0.977	0.964	0.949	0.941
$500,000 / $1,000,000	0.990	0.981	0.971	0.959	0.953
$1,000,000 / $3,000,000	0.992	0.985	0.977	0.967	0.962
$2,000,000 / $4,000,000	0.993	0.987	0.981	0.973	0.969

Policy Limits	Per-Insured Aggregate Deductible (Loss Only)				
	$50K	$100K	$200K	$250K	$500K
$100,000 / $300,000	0.869	0.792	0.680	0.605	N/A
$200,000 / $600,000	0.902	0.831	0.742	0.700	0.600
$250,000 / $750,000	0.909	0.844	0.749	0.699	0.615
$500,000 / $1,000,000	0.927	0.874	0.796	0.747	0.691
$1,000,000 / $3,000,000	0.941	0.899	0.837	0.798	0.747
$2,000,000 / $4,000,000	0.952	0.917	0.866	0.835	0.795

Additional deductible options are available based upon specific group size and specialty. Refer to underwriting

Accelerated Vesting For Extended Reporting Period Endorsement - Form PSIC-CM-02

This endorsement amends the years of continuous coverage requirement for the Extended Reporting Endorsement at no additional charge upon retirement.

Active Military Suspension Endorsement - Form PSIC-CM-03

This endorsement suspends coverage, including premium payments, if an insured is called to active military duty. This endorsement provides coverage for claims arising from acts, errors or omissions that occurred prior to the inception of the active military leave. There is no coverage for acts, errors or omissions during the period of active military duty. For claims made policies, because the policy does not cancel, there is no need for the purchase of Extended Reporting Coverage (Tail) while on active military duty.

Additional Interests Endorsement - Form PSIC-CM-05

This optional endorsement provides coverage for an additional interest. For an individual practice, the charge for this endorsement will be up to 15% of the named insured's undiscounted manual premium for each additional interest. For a group practice, the charge for this endorsement will be up to 15% of the undiscounted manual rate of the top 5 highest rated healthcare providers for each additional interest.

The addition of an additional interest will be based upon the underwriter's assessment of additional exposure imputed to an insured physician and/or surgeon, solo practitioner corporation, partnership or multi shareholder corporation.

Locations or services being provided by the **additional interest** to or on behalf of the Named Insured are financially and medically controlled by the Named Insured.	0%
Locations or services being provided by the **additional interest** to or on behalf of the Named Insured are not financially controlled by the Named Insured.	10%
Locations or services being provided by the **additional interest** to or on behalf of the Named Insured are not financially and medically controlled by the Named Insured.	15%

Temporary Leave of Absence Endorsement - Form PSIC-CM-06

This endorsement may be utilized if an insured must take a leave of absence from their practice. Insureds who become disabled or take a leave of absence shall become eligible for suspension of coverage at a rate reduction of 90% of the otherwise applicable rate for the period of disability or leave of absence. The period must extend for a minimum length of sixty (60) days or more up to a maximum of one hundred eighty (180) days or until renewal. The lower premium will apply retroactively to the first day of the disability or leave.

This option provides continued protection to the provider who experiences a temporary interruption in his or her practice (subject to the stated eligibility requirements), for claims arising from acts, errors or omissions which occurred prior to the inception of the disability or leave. There is no coverage for acts, errors or omissions during the leave or disability period. Because the policy does not cancel, there is no need for the purchase of Extended Reporting Coverage (Tail).

If disabled, proof of disability must be submitted to the Company for approval, and the calculation of the credit will be on a pro rata basis for the period of the qualifying disability.

While on disability or leave, credit toward extended reporting vesting will continue to accrue, and the insured must continue to pay premiums when due.

Eligible Situations For Temporary Leave of Absence: Short-Term Disability, Maternity Leave, Military Leave or any other reason pre-approved by Professional Solutions Insurance Company – Does not apply to vacations.

Extended Reporting Endorsement - Form PSIC-CM-07

This endorsement provides coverage for an unlimited time period with aggregate liability limits equal to or less than those of the expired coverage to report claims, which arose from incidents that occurred when the coverage was in force. The liability limits provided by this option are the only limits that shall be applicable to the unlimited time period designated above. This endorsement can be applied to group or entity policies.

Covered Full Time Equivalent Healthcare Provider Endorsement - Form PSIC-CM-08

A Full-time Equivalency (FTE) is used to accommodate multiple healthcare providers sharing one or more full-time positions within the given specialty. This endorsement provides one separate limit of liability to be shared by the covered FTE healthcare providers within the same FTE position as designated in the endorsement. All covered FTE healthcare providers within an FTE position must have the same specialty. The premium for the FTE position is based on the total hours of practice of the FTE position and the full-time, mature rate for the given specialty.

Covered Healthcare Provider Slot Endorsement - Form PSIC-CM-09

A slot is used to accommodate one full-time position for a given specialty in practices with a high position turnover. This endorsement provides one separate limit of liability to be shared by the covered slot healthcare providers within the same slot position as designated in the endorsement. All covered slot healthcare providers within a slot position must have the same specialty. The premium for the slot position is based on the full-time, mature rate for the given specialty.

Covered Physician Locum Tenens Endorsement - Form PSIC-CM-10

This endorsement adds coverage for the substitute physician or surgeon listed on the endorsement while the named insured is temporarily absent from professional practice. There is no additional premium for this endorsement.

Illinois Restricted Practice Endorsement - Form PSIC-CM-IL-03

This endorsement excludes the designated specialty, procedure or practice activity for the insured(s) specified on the endorsement.

Vicarious Liability for Affiliated Healthcare Provider Endorsement - Form PSIC-CM-12

Coverage is provided for the vicarious liability of the affiliated healthcare provider(s) stated in the endorsement, who at the time of the alleged incident, were not otherwise named as an insured under the policy. There is a 25% additional premium charge for each affiliated physician and a 3% additional premium charge for each affiliated mid-level healthcare provider.

Illinois Vicarious Liability Risks Excluded Endorsement - Form PSIC-CM-IL-04

This endorsement excludes any vicarious liability arising from professional services provided by, or which should have been provided by, any excluded healthcare provider(s) designated on the endorsement.

XVI. CLASSIFICATION PLAN – Refer to rate sheet for manual rate information.

ISO Specialty Codes M.D.	ISO Specialty Codes D.O.	Class	Description	FACTOR
80999		1	Administrative excl. Direct Patient Care	0.650
80133		1	Aerospace Medicine	0.650
80254		1	Allergy/Immunology	0.650
80256		1	Dermatology - No Surgery	0.650
80240		1	Forensic & Legal Medicine	0.650
80248		1	Nutrition	0.650
80233		1	Occupational Medicine	0.650
80263		1	Ophthalmology - No Surgery	0.650
80235		1	Physical & Rehab Med. excl. Chronic Pain Management	0.650
80231		1	Preventive Medicine - No Surgery	0.650
80251		1	Psychosomatic Medicine - No Surgery	0.650

80236	1	Public Health - No Surgery	0.650
80237	2	Diabetes - No Surgery	0.850
80238	2	Endocrinology - No Surgery	0.850
80243	2	Geriatrics - No Surgery	0.850
80244	2	Gynecology - No Surgery	0.850
80260	2	Nephrology - No Surgery	0.850
80262	2	Nuclear Medicine	0.850
80268	2	Physician (NOC) - No Surgery	0.850
80993	2	Podiatry - Soft Tissue	0.850
80249	2	Psychiatry - No Surgery	0.850
80252	2	Rheumatology - No Surgery	0.850
80182	3	Anesthesiology incl. Chronic Pain Management	1.000
80183	3	Anesthesiology	1.000
80255	3	Cardiovascular Disease - No Surgery	1.000
80420	3	Family Practice, GP (excl. OB) - No Surgery	1.000
80241	3	Gastroenterology - No Surgery	1.000
80245	3	Hematology - No Surgery	1.000
80246	3	Infectious Diseases - No Surgery	1.000
80257	3	Internal Medicine - No Surgery	1.000
80302	3	Oncology - No Surgery	1.000
80268	3	Orthopedic Diagnostic (office only) - No Surgery	1.000
80265	3	Otorhinolaryngology - No Surgery	1.000
80182	3	Pain Management	1.000
80266	3	Pathology - No Surgery	1.000
80267	3	Pediatrics - No Surgery	1.000
80269	3	Pulmonary Diseases - No Surgery	1.000
80425	3	Radiation Oncology	1.000
80287	4	Nephrology - Minor Surgery	1.250
80301	4	Oncology - Minor Surgery	1.250
80289	4	Ophthalmology - Minor Surgery	1.250
80114	4	Ophthalmology - Major Surgery	1.250
80294	4	Pulmonary Diseases - Minor Surgery	1.250
80120	4	Urology - Minor Surgery	1.250
80281	5	Cardiovascular Disease - Minor Surgery	1.500
80282	5	Dermatology - Minor Surgery	1.500
80271	5	Diabetes - Minor Surgery	1.500
80272	5	Endocrinology - Minor Surgery	1.500
80421	5	Family Practice, GP (excl. OB) - Minor Surgery	1.500
80274	5	Gastroenterology - Minor Surgery	1.500
80276	5	Geriatrics - Minor Surgery	1.500
80277	5	Gynecology - Minor Surgery	1.500
80278	5	Hematology - Minor Surgery	1.500
80222	5	Hospitalist	1.500
80279	5	Infectious Diseases - Minor Surgery	1.500
80284	5	Internal Medicine - Minor Surgery	1.500
80261	5	Neurology - No Surgery	1.500
80291	5	Otorhinolaryngology - Minor Surgery	1.500
80293	5	Pediatrics - Minor Surgery	1.500
80208	5	Physical & Rehab Med. incl. Pain Mgmt - Minor Procedures	1.500
80294	5	Physician (NOC) - Minor Surgery	1.500
80253	5	Radiology Diagnostic - No Surgery	1.500
80268	5	Urgent Care excl. Emergency Med. - No Surgery	1.500
80145	5	Urology - Major Surgery	1.500

80283	6	Intensive & Critical Care Medicine	1.650
80288	6	Neurology - Minor Surgery	1.650
80292	6	Pathology - Minor Surgery	1.650
80208	6	Physical & Rehab Med. incl. Pain Mgmt - Major Procedures	1.650
80280	6	Radiology Diagnostic - Minor Surgery	1.650
80360	6	Radiology Interventional - including invasive procedures	1.650
80101	7	Broncho-Esophagology - Major Surgery	2.150
80103	7	Endocrinology - Major Surgery	2.150
80104	7	Gastroenterology - Major Surgery	2.150
80105	7	Geriatrics - Major Surgery	2.150
80804	7	Neonatal/Perinatal Medicine	2.150
80108	7	Nephrology - Major Surgery	2.150
80159	7	Otorhinolaryngology excl. Facial Plastic – Major Surgery	2.150
80115	8	Colon & Rectal - Major Surgery	2.500
80164	8	Oncology - Major Surgery	2.500
80117	8	Physician (NOC) - Major Invasive Procedures	2.500
80160	8	Rhinology Surgery	2.500
80102	9	Emergency Medicine - excl. Major Surgery	3.000
80420	9	Family Practice, GP - incl. OB & assist CS	3.000
80143	9	General (NOC) excl. Bariatrics - Major Surgery	3.000
80154	9	Orthopedic excl. Spine - Major Surgery	3.000
80156	9	Plastic (NOC) - Major Surgery	3.000
80169	10	Hand - Major Surgery	3.350
80154	10	Orthopedic incl. Spine - Major Surgery	3.350
80155	10	Otorhinolaryngology incl. Facial Plastic - Major Surgery	3.350
80166	11	Abdominal - Major Surgery	3.750
80157	11	Emergency Medicine - incl. Major Surgery	3.750
80167	11	Gynecology - Major Surgery	3.750
80170	11	Head & Neck - Major Surgery	3.750
80141	12	Cardiac - Major Surgery	4.500
80150	12	Cardiovascular Disease - Major Surgery	4.500
80156	12	Dermatology - Major Surgery	4.500
80144	12	Thoracic - Major Surgery	4.500
80171	12	Traumatic - Major Surgery	4.500
80146	12	Vascular - Major Surgery	4.500
80153	13	OB/GYN - Major Surgery	5.500
80168	13	Obstetrics - Major Surgery	5.500
80152	14	Neurology - Major Surgery	6.750

XVII. PROFESSIONAL ENTITY COVERAGE

A. Solo Practitioner Corporation:

Coverage for an insured's professional entity may be written with a shared limit of liability at no additional charge as long as the entity does not employ any other licensed physicians or surgeons.

B. Shared Limits of Liability:

Coverage for professional entities other than solo practitioners may be written with a shared limit of liability. The charge for shared limits of liability will be 3% of the discounted manual rate, prior to the application of any applicable deductibles, of all insured providers, with the maximum premium limited to a cap of the top 5 highest rated healthcare providers listed of the Declarations and Schedule of Insureds when calculation the premium.

C. Separate Limits of Liability:

Coverage for professional entities may be written with a separate limit of liability. The premium charge for separate limits in which all members, stockholders or employees are insured with Professional Solutions Insurance Company will be 10% of the discounted manual rate, prior to the application of any applicable deductibles, of all insured providers, with the maximum premium limited to a cap of the top 5 highest rated healthcare providers listed on the Declarations and Schedule of Insureds when calculating the premium.

XVIII. MID-LEVEL HEALTHCARE PROVIDER COVERAGE

A. Shared Limits of Liability:

Coverage for licensed, mid-level healthcare providers may be written so the mid-level healthcare providers share a separate limit of liability with another insured as stated on the Schedule of Mid-level Providers. There is no additional premium charge for up to 5 mid-level providers sharing in a separate limit. More than 5 mid-level providers requesting to share in a separate limit will be referred to Underwriting.

B. Separate Limits of Liability:

Coverage for licensed, mid-level healthcare providers is available on an individual, separate limits basis for employees of physicians insured by PSIC.

Mid-Level Healthcare Provider Classification Plan

ISO Specialty Codes	Mid-Level Healthcare Provider	Separate Limit Factor
80998	Other Ancillary Healthcare Provider	0.200
80960	Certified Registered Nurse Anesthetist	0.300
80965	Nurse Practitioner	0.300
80116	Physician Assistant	0.300
80116	Surgeon Assistant	0.300

XVIII. MISCELLANEOUS MEDICAL FACILITIES

Coverage for miscellaneous medical facilities may be written with a separate limit of liability.

Miscellaneous Medical Facility Mature Claims Made Rate (@ 100/300 limits)

Illinois Territory 01 - (Cook, Madison and St. Clair counties)	**$10.94**
Illinois Territory 02 - (DuPage, Kane, Lake, McHenry and Will counties)	**$8.10**
Illinois Territory 03 - (Champaign, Macon, Jackson, Vermillion, Sangamon, DeKalb, Kankakee, LaSalle, Ogle, Randolph, Winnebago and Jackson counties)	**$7.15**
Illinois Territory 04 - (Remainder of State)	**$5.24**

ISO Specialty Codes	Description	Factor
80613	Dialysis Center	0.150 Per Visit
80453	Ambulatory Surgical Center	1.000 Per Surgery
80613	Cancer Treatment Center	0.150 Per Visit
80613	Medical Spa	0.050 Per Visit
80613	Urgent Care	0.200 Per Visit
80715	Laboratory	0.500 Per $1,000 of Receipts
80715	Imaging Facility	0.500 Per $1,000 of Receipts

XX. RATES

Physicians and Surgeons Mature Claims Made Rate (for Class 3 provider @ 100/300 limits)

Illinois Territory 01 - **$10,282.00**
(Cook, Madison and St. Clair counties)

Illinois Territory 02 - **$7,613.00**
(DuPage, Kane, Lake, McHenry and Will counties)

Illinois Territory 03 - **$6,717.00**
(Champaign, Macon, Jackson, Vermillion, Sangamon, DeKalb, Kankakee, LaSalle, Ogle, Randolph and Winnebago counties)

Illinois Territory 04 - **$4,925.00**
(Remainder of State)

Increase limit factors: The applicable limit factor is determined by the chosen limit option on the application.

Limits of Liability	Increase Limit Factors
$100,000/$300,000	1.000
$200,000/$600,000	1.375
$250,000/$750,000	1.500
$500,000/$1,000,000	1.875
$1,000,000/$3,000,000	2.500
$2,000,000/$4,000,000	3.125

Claims-Made Step Factors:

Year	Claims-Made Step Factor
1	0.250
2	0.500
3	0.780
4	0.925
Mature	1.000

6th Month Rule: If the period between the retroactive date and the policy effective date is less than 6 months, rate at year 1. If the period is more than 6 months, rate at year 2, with each of the next consecutive claims made step increases applied at each renewal.